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MEDICARE-MEDICAID ANTIFRAUD AND ABUSE AMENDMENTS

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

AND THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT
COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE
U.S. HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

H.R. 3

A BILL TO STRENGTHEN THE CAPABILITY OF THE GOVERNMENT TO DETECT, PROSECUTE, AND PUNISH FRAUDULENT ACTIVITIES UNDER THE MEDICARE AND MEDICAID PROGRAMS, AND FOR OTHER PURPOSES

MARCH 3 AND 7, 1977

Serial 95–7

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MEDICARE-MEDICAID ANTIFRAUD AND ABUSE AMENDMENTS

THURSDAY, MARCH 3, 1977

House of Representatives,
Subcommittee on Health of the
Committee on Ways and Means, and
Subcommittee on Health and the Environment of the
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittees met jointly, pursuant to notice, at 10:10 a.m., in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the Subcommittee on Health) and Hon. Paul Rogers (chairman of the Subcommittee on Health and the Environment) presiding.

Mr. Rostenkowski. The joint subcommittees will come to order.

The hearings that we begin today are important ones, both for the committees involved and for the Congress as a whole. For the two committees they represent a strong public committment to work together on issues of mutual concern. Although much has been written about so-called jurisdictional jealousy in the health area between the Ways and Means Committee and the Interstate and Foreign Commerce Committee, we have always had the ability to work together on legislation affecting both medicare and medicaid programs.

Our joint hearings on H.R. 3 are but a formal embodiment of the spirit of cooperation that has always existed between Chairman Rogers and myself. For the Congress, the joint appearances of the two House health subcommittees here this morning, coupled with the presence of our old friend, the new Secretary of Health, Education, and Welfare, represents a public commitment to address the pervasive problems of fraud and abuse in our Federal health financing programs, problems that have been disclosed in all too many sensational headlines during the past few years.

While H.R. 3 will not stop every fraudulent or abusive practice, it is certainly a beginning. It should be viewed as an initial response to the Congress that these practices must stop. While the language of H.R. 3 chiefly addresses technical problems in present law, the spirit of cooperation and commitment that led to the development of H.R. 3 will, if Mr. Rogers and I have anything to say about the matter, lead to continuing work to improve these programs which are crucial to the well-being of our elderly and our poor.

We will work not only on legislative modifications as they are necessary, but also to continually review the day-to-day operation and administration of our programs to insure that needed health care dollars are only channeled as originally intended by the Congress.

Before yielding to my colleague from Florida, I would like to make these brief housekeeping announcements. First, the joint hearing will result in an unusually large number of members participating in this hearing.

We hope that in their questioning they will try to stay within the 5-minute rule.

Second, the staff will make available to the press and the public all the additional copies of the testimonies that are available. However, since several witnesses have failed to comply with the rule concerning submission of testimony to the committee 24 hours prior to the hearing, and in sufficient numbers to be readily available, we hope the press and the public will bear with us on this matter.

In this regard, if there are any witnesses in the room who fail to meet the deadline for submission of testimony, but have their testimony with them, could they please come forward and give it to the committee staff so that it will be available to the members. I would only point out that our rule concerning submission of testimony before the hearing is designed to allow the committee to make the best use of its limited time.

Finally, I would like to insert at this point in the record, a copy of the press release announcing this hearing.

[The press release follows:]

[Press Release of Thursday, Feb. 3, 1977]

THE HONORABLE DAN ROSTENKOWSKI (D., ILL.,), CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS, AND THE HONORABLE PAUL G. ROGERS (D., FLA.), CHAIRMAN, SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE, ANNOUNCE A TWO-DAY JOINT HEARING ON MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS, H.R. 3, TO BE CONDUCTED THURSDAY, MARCH 3, AND MONDAY, MARCH 7, 1977

The Honorable Dan Rostenkowski, (D., Ill.), Chairman of the Subcommittee on Health, of the Committee on Ways and Means, and the Honorable Paul G. Rogers (D., Fla.), Chairman of the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, announced today that their Subcommittees will hold joint hearings on the Medicare-Medicaid Anti-Fraud and Abuse Amendments, H.R. 3. These hearings will be conducted on Thursday, March 3, 1977, in the Ways and Means Committees Main Hearing Room, across the hall from Room 1102 Longworth House Office Building, and on Monday, March 7, 1977, in the Interstate and Foreign Commerce Committee's Main Hearing Room, 2123 Rayburn House Office Building.

BACKGROUND INFORMATION REGARDING THE HEARING TOPIC

Disclosures during the past few years have focused increased congressional attention on the problems of fraud and abuse in the federal health financing programs, medicare and medicaid. The Subcommittees are interested in receiving testimony commenting on the specific provisionn of H.R. 3 and other proposals pertaining to the topic of fraud and abuse in medicare and medicaid. It should be emphasized that testimony will be taken only on issues relevant to fraud and abuse in medicare and medicaid. Testimony pertaining to other aspects of these programs or to the subject of national health insurance will not be heard at this time.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Cutoff Date for Requests to be Heard, etc.—Requests to be heard must be received by the Committee no later than the close of business, Friday, February 15, 1977.

Requests should be addressed to John M. Martin, Jr., Chief Counsel, Committee on Ways and Means, U. S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The telephone number is (202) 225-3625. Notification of a witness' scheduled date of appearance will be made as promptly as possible after the cutoff date. Once a witness has been advised of his date of appearance, it is not possible for this date to be changed. If a witness finds he cannot appear on that day, he may wish to either substitute another spokesman in his place or file a written statement for the record of the hearing instead of appearing in person. In any event, if a change in witness or a cancellation becomes necessary, please advise the Committee office immediately.

Allocation of Time to Witnesses.—Due to the limited time available for this hearing, it may be necessary to limit the number of witnesses and will be necessary to allocate the amount of time available to each witness for the presentation of his oral testimony. It will be *mandatory* on all witnesses not to exceed the time allocated for this purpose. Each witness must present his oral statement in summary form; a more detailed statment will be accepted for inclusion in the printed record of the hearing. If necessary, witnesses may be grouped into panels to further expedite the hearing process. Additionally, all persons and organizations having a common position should exert the maximum effort to designate one spokesman to represent them.

REQUESTS TO BE HEARD MUST CONTAIN THE FOLLOWING INFORMATION:

(1) The name, address and capacity in which the witness will appear.

(2) A topical outline or summary of the comments and recommendations which the witness proposes to make.

It is requested that persons scheduled to appear before the Subcommittees submit 75 copies of their prepared statements to the Ways and Means Committee office (Room 1102 Longworth House Office Building) no later than 24 hours in advance of their scheduled appearances. An additional supply may be furnished for distribution to the press and the public on the date of appearance.

Written Statements in Lieu of Personal Appearance.—Any person or organization may, instead of a personal appearance, file a written statement for inclusion in the printed record of the hearing. For this purpose, 5 copies of the statement should be submitted by the close of business, Friday, March 7, 1977. Additional copies may be furnished for distribution to the Members of the Subcommites, the staff, press and public, if submitted to the Committee during the course of the hearings.

Mr. Rostenkowski. Mr. Secretary, at this point I would like to yield to my cochairman in this hearing, a man that I once served with on the Interstate and Foreign Commerce Committee, at his elbow then as I do now, my friend, Paul Rogers.

Mr. Rogers. Thank you very much, Mr. Chairman.

I and my colleagues on the Subcommittee on Health and Environment are very honored to be with you and the members of your subcommittee to open these joint hearings in a measure to combat fraud and abuse in the medicare and mericaid programs. The occasion, as Chairman Rostenkowski has said, marks the most visible sign to date of the cooperation and jont action between the two major subcommittees of the House concerned with health care issues.

We do share mutual concerns in making our health care system, which is increasingly supported by Federal tax dollars, more responsive, more humane, and more effective, and operated without taint of misuse, abuse or fraud. Of course, the measure before us today cannot achieve all of these goals because we need to examine fundamental changes in the structure and coverage of our financing programs if we are to solve many of the major problems beneficiaries of medicaid and medicare face.

We need to find ways to improve the delivery system if we are truly to make available adequate health care services to inner-city and rural residents.

Our committee has been pleased to work with members and staff of the Senate and the House, HEW, the Department of Justice, and the States themselves in developing and importing the piece of legislation we now have before us. It can be improved further, I am sure, and we look forward to receiving the advice of the witnesses here today and those appearing next Monday in this regard.

We join with Chairman Rostenkowski in particularly welcoming today our old friend, the new Secretary of HEW, Mr. Califano; and, Mr. Secretary, your presence today affirms what I know is your strong commitment to reduce the problems of fraud and abuse in medicaid and medicare.

While improved legislation can assist in meeting these objectives, only strong and effective administration of these programs at the Federal and State level can really solve the problem, so we look forward to working with you on this bill and on future proposals to control costs and improve services in our health financing programs. On a personal note, I am particularly pleased to be here and work with Danny Rostenkowski and the members of his subcommittee to let the public know that we do work in a cooperative spirit trying to serve the needs of the Nation in the health area. So I join in welcoming you, Mr. Secretary.

Mr. Rostenkowski. Thank you, Mr. Rogers.

Mr. Duncan?

Mr. Duncan. I am pleased to welcome our witnesses and guests to this extremely important hearing. We have all heard a great deal about the problem of fraud and abuse, and I am glad that we are at least taking the bull by the horns in doing something to control this disgraceful situation.

Also, I would like to say that I am particularly pleased that this hearing is being conducted jointly with our distinguished colleagues of the Subcommittee on Health and Environment of the Committee on Interstate and Foreign Commerce. I think that in considering the testimony we will hear today, we will need to bear in mind a very important point, namely, not to succumb to any temptation to let the providers of our health care cheat our system.

I very much look forward to this hearing and learning a great deal about the nature of this problem and suggestions that deal with this. We also welcome you, Mr. Secretary.

Mr. Rostenkowski. Dr. Carter?

Mr. Carter. Mr. Chairman and members of the subcommittees, it is indeed a pleasure to participate in these 2 days of joint hearings between our health subcommittees. I trust we will have a productive session and I look forward to similar opportunities for cooperation in the future.

Mr. Chairman, for the past several years congressional hearings and investigations have revealed widespread reports of fraud and abuse in the medicare and medicaid programs. Estimates of the costs of these activities range from about $750 million to $4 billion a year.

This is a serious situation. The effects of fraud and abuse are felt not only by individual patients who may be receiving care, or perhaps no care at all, but also by every taxpayer when Federal dollars are wasted. I share the other members' concern about this problem and I hope that as we legislators can move in a timely fashion to help correct it.

Yet, developing corrective legislation is only part of the solution. We need to have effective administration of existing authorities at all levels—Federal State and local. Some of the problems of fraud and abuse may require new legislative authorities. Others may be more adequately addressed by stricter administrative enforcement.

It is my hope that in these hearings the witnesses will help advise our subcommittees as to precisely where new legislative authority is needed and also where stricter enforcement of current authority would be the best approach to dealing with fraud and abuse problems.

Mr. Chairman, I am a cosponsor of this legislation because I support its objectives to strengthen the capability o fthe Government to detect, prosecute, and punish those involved in fraudulent activities under the medicare and medicaid programs. Yet I have a few general concerns which I would like to include for the record and which I hope we can examine closely in the course of the hearings. These concerns include the PSRO provisions of the legislation, the definition of "shared health facility," and the effect of this legislation on provider participation in medicare and medicaid.

First, I do have strong reservations about involving PSRO's in the review of shared health facilities. As the PSRO program now exists, it is essentially a quality control program, whereby the quality and necessity of health services under medicare and medicaid are reviewed. I am concerned the thrust of the proposed changes in this legislation will place the PSRO in an invetigative, fraud-detector role. In my view, PSRO's should not become the "arms" of law enforcement bodies. Such a significant change in policy could undermine the function of the PSRO's of quality control.

I am also concerned that PSROs are not yet ready to undertake review of ambulatory care on a widespread basis. I do not believe that the appropriate procedures and criteria for that type of review have been adequately developed and tested. At this time, many PRSOs are just getting off the ground in their review of hospital care and I think it would be unwise to place a new emphasis on ambultory care as this legislation does, in regard to review of shared health facilities. Recent reports by the Institute of Medicine and HEW's Health Resources Administration's National Center for Health Services Research indicate that there is a great deal of research that needs to be done before the proper quality assurance review procedures are developed and tested for ambultory care. I hope we will consider this evidence as we review the proposed legislation.

Second: I am concerned about the scope of the definition of "shared health facility." I am concerned that it may be too broad. As it reads now, most group practices could be involved.

Third: I have a general concern about the potentially determental effect of some of these provisions on provided participation in the medicare and medicaid programs—and thus the detrimental effect of care of the poor and elderly. Already we know that many physicians have chosen not to participate in these programs because of the increasing amount of bureaucratic red tape which is involved. The more conditions and requirements we impose, the more we will discourage providers from participating. Regrettably, it is the programs' beneficiaries who bear the ultimate burden in loss of needed services.

Finally: I hope the subcommittees will consider some alternatives to detection and prosecution of fraudulent practices. I hope we can develop some preventive initiatives to deal with the causes of these problems. What may be needed, for example, is the development of an alternative source of care for medicaid-eligible people to replace the medicaid mills. We explored some of these last year, and I hope we will give them careful consideration again, so that we can provide a truly comprehensive approach to dealing with the fraud and abuse problem.

Thank you, Mr. Chairman.

Mr. Rostenkowski. Thank you, Dr. Carter.

Mr. Secretary, the committees are now ready for your words of wisdom.

STATEMENT OF HON. JOSEPH A. CALIFANO, JR., SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Secretary Califano. Members of the committee, let me begin by saying that I think this is a "first," in the context of the Carter administration, in which two committees of the Congress have held a joint hearing. I bring to this committee the appreciation of the President for conducting a hearing in this manner, because in addition to showing and symbolizing tremendous cooperation within the Congress itself, it seems to me it is also an important symbol of a renewed relationship between the Congress and the executive branch. I deeply appreciate it and President Carter deeply appreciates it.

The elimination of fraud and abuse in the medicare/medicaid programs is one of HEW's highest priorities, and we are eager to work with the subcommittees in developing legislation to give us more of the tools we need to do the job.

We strongly support the outlines of H.R. 3 because it would: (1) Strengthen the Government's ability to detect and take action against fraudulent and abusive activities by program providers, suppliers, and individual practitioners; and (2) encourage more efficient and effective use of Federal and State funds.

I recognize that much of the impetus for dealing with the problems of fraud and abuse in our medicare and medicare programs has come from the Congress in recent years. As a citizen, I come here today to express my appreciation to these committees for their leadership in this area. As Secretary of HEW, I come here today to stress my strong personal commitment, the commitment of my Department, and the commitment of the President to the objectives of H.R. 3.

I want to assure you that the executive branch will now join with you in aggressively pursuing the abuses and frauds that too often attend the medicare and medicaid programs.

We are, as you know, discussing programs of great magnitude. Medicare reaches 25 million people and costs approximately $22 billion a year in Federal dollars. Medicaid also reaches 25 million people per year and costs a total of $18 billion, with the Federal share at $10 billion.

I recognize that the great majority of those involved in medicare and medicaid are wholly honest and seek only to provide or receive the care that is due. But this general probity only makes our task more urgent.

Those who exploit and abuse medicaid and medicare corrupt the Nation's effort to provide decent medical care to those most in need and corrode public confidence in our entire health care system. Your leadership in pointing up the great need for reform in this area and in devising weapons which we can use to solve the problem are of invaluable service to HEW and to the American people.

There are many problems, Mr. Chairman. For example, four cases just discovered by our audit agency's review of medicaid illustrate this problem:

According to medicaid records, on each of 42 different days in a single year one beneficiary had the same prescription filled twice for the same drug at the same drug store.

During 1 year, there were payments for one medicaid beneficiary covering 298 prescriptions filled at five drug stores.

During a single year, a physician was paid for 5,500 comprehensive office examinations of 2,009 medicaid patients. According to the records, one patient received 43 comprehensive examinations from that physician in 1 year. Payments for comprehensive examinations amounted to $155,500 of that physician's total medicaid billings of $220,800.

Another, a physician in general practice was paid $73,000 for 10,500 separate services to 225 medicaid patients over an 11-month period—including an average of 42 lab tests per patient compared with the statewide average of 3.

With expenditures of almost $40 billion annually, improved management and control of fraud and abuse can effect savings of great significance. I want to effect savings, and H.R. 3 will help HEW achieve them. We should also recognize that much of our unnecessary medical costs in this area result from abusive practices, not just from outright fraud.

Substantial savings are attainable, not only because of the Department's concern and your leadership, but also because of the other actions which have been initiated by the Congress, the executive branch and the States in response to the public outrage across the Nation to medicare and medicaid fraud abuse. It is important to see H.R. 3 in the context of these current efforts to root out fraud and abuse in Federal health programs, although it is important to recognize that these efforts are only initial steps and will not by themselves solve the problem.

For example: Within HEW, we are beginning to reap greater benefits from past efforts to improve the management of medicare and medicaid programs. We have over 300 trained people in Washington and the regions who are using innovative techniques to ferret out instances of fraud, abuse, and waste.

Efforts have long been underway in the medicare program—over 45,000 cases of possible fraud and abuse have been investigated since this program's inception. Using similar techniques, the medicaid program has begun to improve its management capability in the past two years and is now conducting special studies in selected States using sampling techniques of providers.

A Massachusetts study, for example, revealed irregularities in 20 percent of the physician claims reviewed; 34 percent of the pharmacy claims; and 16 percent of the laboratory claims. Those irregularities, I should note, may include a significant number of recordkeeping irregularities. They also included billings for services not rendered, duplicate billings, the dispensing of more expensive drugs than those prescribed, or the charging of more than usual and customary fees. In 1976, 71 medicare providers were convicted—over three times more than in 1975.

Efforts to combat fraud and abuse have been initiated by the Department of Justice in cooperation with HEW. I am sure Mr. Skinner, the U.S. attorney in Chicago, will amplify on this when he testifies before you.

I would note that Attorney General Bell and I have discussed this matter, and have exchanged correspondence assuring continued and expanded joint efforts.

The action of the Congress in the last session to establish the Office of the Inspector General (Pub. L. 94–505) is a major step forward. Under this statute, we will have a new senior executive in HEW—Tom Morris—who reports jointly to the Congress and the Secretary. He will be responsible for Department-wide audits and investigations, and for promoting economy and efficiency in all HEW programs. But he will pay special attention to health care programs and medicare/medicaid fraud and abuse.

I am also encouraged by the prospect of Federal-State cooperation to improve program management, especially in the fraud area. For example, following our current review of medicaid providers in the State of Georgia, we will establish, with the cooperation of Governor Busbee, a task force of Federal and State personnel to investigate cases of suspected fraud. These teams will consist of personnel from the Georgia Bureau of Investigation, HEW's Office of Investigation, and the Federal medicaid staff.

We also have similar teams in place in Ohio and New York.

We are conducting assessments of each State's fraud and abuse detection capabilities, and recommending corrective actions where needed. Emphasis is being placed, as well, on technical assistance to State fraud and abuse investigators. Several seminars have been held to train investigators and prosecutors.

The HEW audit staff has developed a computer analysis technique which can be quickly applied in most of the States to identify, for further study, instances of gross abuse in medicaid and medicare payments such as those I cited earlier.

H.R. 3 will add significantly to these initial steps which we have taken and which are underway to combat fraud and abuse.

With respect to the specific provisions. I would like to emphasize that I strongly support the sections which (*a*) increase to the felony level those criminal penalties for providers who defraud and (*b*) require the Secretary to suspend practitioners convicted of a criminal offense relating to either medicaid or medicare. Those providers and practitionrs who defraud and abuse the medicare/medicaid systems not only violate the laws of our land: they are craven profiteers who prey on the poor and the sick and the old—the most vulnerable human beings of our society.

With respect to many other details in this complicated piece of legislation that Chairman Rostenkowski and Chairman Rogers and others have introduced and cosponsored, there must be a continuous dialog between staffs on the Hill and staffs in HEW on the ultimate framing of various provisions. I hope that such discussions can begin immediately. I know that they will be a valuable prelude to development of the final piece of legislation.

I have asked Grant Spaeth, the new Deputy Assistant Secretary for Legislation in the health care, to give this item, working with your staff, top priority and to lead the HEW effort in cooperating with your staff.

In closing, I wish to reiterate that I personally wanted to come before you this morning and to state my appreciation and support for your efforts to eradicate the abuses in our governmental health programs which have became such a justified cause of concern and, at times, outrage to the American people.

Your committees have been at the forefront of trying to solve the problems of fraud and abuse in these areas.

[The prepared statement follows:]

STATEMENT OF JOSEPH A. CALIFANO, JR., SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and members of the subcommittees, I appreciate the opportunity to present the views of the Department of Health, Education, and Welfare on H.R. 3, the Medicare/Medicaid Anti-Fraud and Abuse Amendments.

The elimination of fraud and abuse in the Medicare/Medicaid programs is one of HEW's highest priorities, and we are eager to work with your Subcommittees in developing legislation to give us more of the tools we need to do the job.

We strongly support the outlines of H.R. 3 because it would:

Strengthen the Government's ability to detect and take action against fraudulent and abusive activities by program providers, suppliers and individual practitioners.

Encourage more efficent and effective use of Federal and State funds.

I recognize that much of the impetus for dealing with the problem of fraud and abuse in our Medicare and Medicaid programs has come from the Congress in recent years. As a citizen I come here today to express my appreciation to these committees for their leadership in this area. As Secretary of HEW, I come here today to stress my strong personal commitment, the commitment of my Department, and the commitment of the President to the objective of H.R. 3. I want to assure you that the Executive Branch will now join with you in aggressively pursuing abuses and fraud that too often attend the Medicare and Medicaid program.

We are, as you know, discussing programs of great magnitude. Medicare reaches 25 million people and costs approximately $22 billion a year in Federal dollars. Medicaid also reaches 25 million per year and costs a total of $18 billion dollars, with the Federal share at $10 billion.

I recognize that the great majority of those involved in Medicare and Medicaid are wholly honest and seek only to provide or receive the care that is due. But this general probity only makes our task more urgent.

Those who exploit and abuse Medicaid and Medicare corrupt the nation's effort to provide decent medical care to those most in need and corrode public confidence in our entire health care system. Your leadership in pointing up the great need for reform in this area and in devising weapons which we can use to solve the problem are of invaluable service to HEW and to the American people. For example, four cases just discovered by our audit agency's review of Medicaid illustrate the problem:

1. According to Medicaid records on each of 42 different days in a single year one beneficiary had the same prescription filled twice for the same drug at the same drug store.
2. During one year, there were payments for one Medicaid beneficiary covering 298 prescriptions filled at five drug stores.
3. During one year, a physician was paid for 5,500 comprehensive office examinations of 2,009 Medicaid patients. According to the records, one patient received 43 comprehensive examinations. Payments for comprehensve examinations amounted to $155,500 of that physician's total Medicaid billings of $220,800.
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With expenditures of almost $40 billion annually, improved management and control of fraud can effect savngs of great significance. I want to effect savings, and H.R. 3 will help HEW achieve them. We should also recognize that much of our unnecessary medical costs in this area results from abusive practices, not just from outright fraud.

Substantial savings are attainable, not only because of the Department's concern and your leadership, but also because of the other actions which have been initiated by the Congress, the Executive Branch and the States in response to the public outrage across the nation to Medicare and Medicaid abuses. It is important to see H.R. 3 in the context of these current efforts to root out fraud and abuse in Federal health programs, although it is important to recognize that these efforts are only initial steps and will not by themselves solve the problem. For example:

Within HEW, we are beginning to reap greater benefits from past efforts to improve the management of Medicare and Medicaid programs. We have over 300 trained people at Washington and in the Regions who are using innovative techniques to ferret out instances of fraud, abuse and waste.

Such efforts have long been underway in the Medicare program—over 45,000 cases of possible fraud and abuse have been investigated since this program's inception. Using similar techniques, the Medicaid program has begun to improve its management capability in the past two years and is now conducting special studies in selected States using sampling techniques of providers. A Massachusetts study revealed irregularities in 20 percent of the physician claims reviewed; 34 percent of the pharmacy claims; and 16 percent of the laboratory claims. Such irregularities included billings for services not rendered, duplicated billings, the dispensing of more expensive drugs than those prescribed, or the charging of more than usual and customary fees. In 1976, 71 Medicare providers were convicted—over three times more than in 1975.

Efforts to combat fraud and abuse have been initiated by the Department of Justice in cooperation with HEW. Attorney General Bell has just written me confirming his personal interest in continuing this cooperation—and expressing his satisfaction with the establishment of HEW task forces to work directly with U.S. Attorney's Office on Medicare and Medicaid fraud. I have assured the Attorney General that we not only wish to continue these efforts but that I will aggressively seek to expand them.

The action of the Congress in the last session to establish the Office of the Inspector General (Public Law 94-505) is a major step forward. Under this statute, we will have a new senior executive in HEW who reports jointly to the Congress and the Secretary. He will be responsible for Department-wide audits and investigations, and for promoting economy and efficiency in all HEW programs. But he will pay special attention to health care programs.

Currently, the offices which will report to the Inspector General are devoting approximately 175 staff years of effort to health care. With the appointment of the Inspector General this effort will grow.

I am also encouraged by the prospect of Federal-State cooperation to improve program management especially in the fraud area. For example, following our current review of Medicaid providers in the State of Georgia, we will establish, with the cooperation of Governor Busbee, a task force of Federal and State personnel to investigate any cases of suspected fraud. These teams will consist of personnel from the Georgia Bureau of Investigation, HEW's Office of Investigation, and the Federal Medicaid staff.

We are also conducting assessments of each State's fraud and abuse detection capabilities, and recommending correctional actions. Emphasis is being placed, as well, on technical assistance to State fraud and abuse investigators, and several seminars have been held to train both investigators and prosecutors.

The HEW Audit Staff has developed a computer analysis technique which can be quickly applied in most of the States to identify for further study instances of gross abuse in Medicaid and Medicare payments such as those I cited earlier. Application of this computer technique has revealed instances of excessive prescriptions being filled for a single beneficiary; excessive numbers of comprehensive physical examinations for a single beneficiary; and excessive laboratory services per patient. We believe that such periodic analyses will spotlight specific abuses, making timely investigations and corrective action a reality.

H.R. 3 will add significantly to these initial steps which are underway to combat fraud and abuse in Medicare and Madicaid.

With respect to specific provisions, I should emphasize that I strongly support the sections which increase to felony level those criminal penalties for providers who defraud and which require the Secretary to suspend practitioners who are convicted of a criminal offense relating to either Medicaid or Medicare. For those providers and practitioners who defraud and abuse the Medicare-Medicaid systems not only violate the laws of our land; they are craven profiters who prey on the poor and the sick and the old—the most vulnerable human beings of our society.

With respect to many other details in this complicated piece of legislation, there must be a continuous dialogue between staffs on the Hill and staffs in HEW on the ultimate framing of various provisions. I hope that such discussions can begin immediately and I know that they will be a valuable prelude to development of the final piece of legislation.

I wanted personally to come before you this morning and to state my appreciation and support for youre efforts to eradicate the abuses in our governmental health program which have become such a justified cause of concern and, at times, outrage, to the American people.

Thank you.

Mr. Rostenkowski. Thank you, Mr. Secretary. I am sure I speak for all the members when I say that we certainly want to cooperate with you. We have been depressed by the extent of the fraud and abuse in the medicare/medicaid area. We sometimes feel that legislation or legislative action alone just won't stop fraud.

Administrative reform, not only on the Federal level, but on the State level is necessary; and I would like for you know that if we can be of service to you—if you need more administrative tools with which to work in order to enforce, and through enforcement deter the fraud and abuse that has been running so rampant, I certainly want to cooperate with you.

I want to thank you very much. This is a problem that I think the American people want addressed Chairman Rogers and I are committed together to solve these problems.

Mr. Rogers?

Mr. Rogers. Thank you very much. I do share those feelings. I think your statement was a strong commitment to do something about this problem and I know the American taxpayer will be pleased to know of the commitment of the Department. I have heard there has been not a very high priority over the years by the Department of Justice. I think it might be helpful if you could carry the message back, and we will also contact the Attorney General and urge him to give us his assurance that he will place authority on this. It is our understanding that some of the district attorneys don't care to devote time to these relatively minor cases.

I think it is important for us to get that cooperation. I got from your statement that you anticipate this will be done.

Secretary CALIFANO. Yes, I do, Mr. Chairman. I think your comments are well taken as far as the past is concerned. I think there is a greatly increasing interest in this area on behalf of the offices of U.S. attorneys. I am sure Mr. Skinner will speak to some of that. I expect that Attorney General Bell will rev up the interest, if you will, of the Justice Department in this area.

Any encouragement from these subcommittees would be greatly appreciated.

Mr. ROGERS. We will invite the Attorney General, if his schedule permits, to testify next Monday.

Let me just ask one more question and then I will conclude.

I wonder if it would be helpful for institutional providers under medicare and medicaid to have a uniform system of accounting? It seems to me that when we get into the problems, we have so many accounting systems that it is difficult for people checking to be able to determine actual expenditures.

What would be your general reaction? I know you may not want to make a commitment at this time.

Secretary CALIFANO. Mr. Chairman, without making a specific commitment, let me indicate that it seems clear to me that we need a more uniform system of reporting, certainly for purposes of getting better understanding of the galloping costs like hospital charges. I think that we probably would like to have more uniformity in accounting of similiar types of entities.

There are many different kinds of hospitals, and I would like to work out some kind of a system which would take that into account. There is no question that more uniformity would be an aid both in terms of putting some reins on the wildly rising hospital charges and also in putting some reins in this area of fraud and abuse with which these subcommittees are so concerned.

We will be focusing on this topic within the Department and with your staffs.

Mr. ROGERS. Thank you. I think we do need to move in that area. Finally, I presume you will use the Inspector General's office as a tool to get at this problem of fraud.

Secretary CALIFANO. Mr. Chairman, I spent as much time trying to select the right person to be nominated as Inspector General as any other post over there. Mr. Morris has had a great deal of experience as an Assistant Comptroller General, as an Assistant Secretary of Defense.

As soon as he is in place—and he is already beginning to work on those problems now—it will be a strong office.

Mr. Rogers. Thank you, Mr. Secretary. Your testimony is most helpful.

Mr. Rostenkowski. Mr. Duncan?

Mr. Duncan. Mr. Secretary, do you see any conflict or duplication of effort and also—by the Inspector General and also the Comptroller General in their joint duties?

Secretary Califano. No, I don't.

Mr. Duncan, indeed, the Inspector General-designate and I met with the Comptroller General about 2½ weeks ago. We spent about 5 hours with Mr. Staats and his staff. I think the two offices will work very well and very cooperatively. In fact, Mr. Staats has been most helpful in giving us ideas as to how the Office of Inspector General might be set up.

HEW, with a $145 billion budget and 145,000 employees, is like a little government. HEW needs its own internal comptroller, which is what we intend to make the Inspector General.

Mr. Duncan. What State have you had the greatest fraud in?

Secretary Califano. I can't answer that and I am not sure it is possible to answer that, Mr. Duncan. It may simply be a function of population, but I think at this point——

Mr. Duncan. For example, I have read of fraud in New York City.

Secretary Califano. Whether that is a function of the population of New York City, the caliber of the reporting in New York City, the fact of Mr. Hynes prosecuting in New York City or a function of more corruption there, I am not prepared to say.

Mr. Duncan. You indicate you have a joint operation with the State of Georgia. What about the other States that seem to have—there is perhaps less fraud in Georgia than the other States?

Secretary Califano. We have been in touch with Governor Busbee. He, just as HEW, wanted that joint effort as a result of factual findings. Other States in which we have joint HEW-Justice-State task forces in the fraud area are New York, New Jersey, and Ohio.

In time there will obviously be more of these task forces, provided they work well.

Mr. Duncan. Are you considering the fact that in your various investigations, that a burden might put upon the providers and really penalize those who are not guilty of fraud? Are you considering that?

Secretary Califano. Yes, Mr. Duncan, I am. I am by profession a lawyer. For the last 8 years I have been practicing law. In the course of that, I have become very sensitive to the rights of individuals and institutions under Federal investigations.

Mr. Duncan. Thank you very much.

Thank you, Mr. Chairman.

Mr. Rostenkowski. Mr. Carter?

Mr. Carter. Thank you, Mr. Chairman.

Mr. Secretary, I wonder if you would comment on whether or not PSRO's are really ready to undertake review of shared health facilities in light of the following quotation that is taken from the Institute of Medicine's recent report entitled "Assessing Quality in Health Care." (November 1976.)

Concerning long-term recommendations for ambulatory quality assurance, the report states: Intensified research and development is needed for ambulatory quality assessment methods. A single approach to quality assurance will not accommodate the diversity of functions and personnel included within the ambulatory service care sector, further research is required before a range of proved alternative methods can emerge.

Secretary CALIFANO. Dr. Carter, we have about 14 in the planning stage and about 106 in what we call the conditional phase. We had hoped within a 2-year period to have about 203 that would be operational.

We need more time. We will be discussing in connection with this bill our plans to get the 203 operational. I do think that PSRO's are one of the tools that should be used and that they should move into the arena of shared health facilities. The speed with which we can move PSRO's into that area is something on which we will need some flexibility, but our feeling is that the system is working. It is, as you indicate from the quotation, only one of several ways of doing it, but we need more than one way to look at the provision, the utilization and the abuse of health care services.

Mr. CARTER. Mr. Secretary, I am concerned that in developing this legislation we are careful to distinguish between the need for new authority and the need for stricter administrative enforcement of existing law. With that focus in mind, would you be able to outline the major gaps in HEW's current fraud and abuse detection authority.

I am particularly interested to know what additional authority you feel is needed beyond the recently enacted legislation which created the Office of Inspector General.

Secretary CALIFANO. Well, without getting into a lot of specifics, Dr. Carter, I believe that we regard most of the provisions of this bill as necessary and as helpful additional tools. I am not prepared to go through the legislation clause by clause, because it is such an important and complex piece of legislation. I have asked Mr. Spaeth to take that on with your staffs as my representative and go through the bill item by item.

I am sensitive to the general principle that you enunciate, however. I realize that government should not get any more authority than it absolutely needs. We need most of the authority contained in this bill to give us better tools to fight fraud and abuse.

Mr. CARTER. Mr. Secretary, if our subcommittees were to decide that PSRO's were not yet ready to undertake review of shared health facilities, what alternative approaches would you recommend to deal with the medicaid mills?

Secretary CALIFANO. Well, let me respond in this way, if I may. If there are alternative suggestions, we will submit them for the record. As for PSRO's themselves, I would hope that HEW will be given time and flexibility.

Mr. CARTER. Certainly you are going to need time.

Mr. Secretary, section 5 of the legislation would give the Secretary of HEW authority to require a PSRO to perform—in addition to hospital review—only such duties and functions as he determines such organization to be capable of performing. How do you expect to review and assess the PSRO's capabilities?

Secretary Califano. I think we would do it PSRO by PSRO. We would do it on an individual basis. To the extent it was possible, we would try to have standards as we have standards now for determining when they move from planning to conditional to operational status.

Mr. Carter. Thank you, Mr. Chairman.

Mr. Rostenkowski. Mr. Corman will inquire.

Mr. Corman. Mr. Secretary, there seems to be strong evidence we will soon be moving into a national health insurance program of some kind. Obviously cost control is of tremendous importance. I assume this part of cost control is also an important part of the total picture. Is that a reasonable observation?

Secretary Califano. Yes, Mr. Corman. We regard the legislation focussed on cost containment as one of the essential building blocks on the road to a fair and equitable health service plan for all Americans which will come through a form of national health insurance.

Mr. Corman. Fine. You have my pledge to support you in that effort and I look forward to working with you.

Thank you very much for your statement.

Secretary Califano. Thank you, Mr. Corman.

Mr. Rostenkowski. Mr. Pike will inquire.

Mr. Pike. Mr. Chairman, I am obliged to start off with a statement which you have heard me make before, but the Secretary has not heard me make before, and Mr. Rogers has not heard me make before; but in view of the fact that I am a cosponsor of this legislation, in view of the great activities in the House of Representatives yesterday on the subject of ethics and in cooperation will all of those spirits, I would like to start by saying that I, for 29 years, have been associated with a health provider; and I want to reveal this on the basis of ethics.

So, Mr. Secretary, I think your statement is excellent; and the one area that concerns me is the question of the cooperation between State and Federal agencies in this regard. One of the reasons, not a principal reason, but one of the reasons that health care costs are high is the fantastic volume of paperwork which providers are now drowning in, trying to keep up with Federal regulations, State regulations and county regulations. Is there any way that the cooperative efforts of the Federal and State agencies can get not only the providers to provide uniform systems of accounting, but the various agencies to ask the same questions to enable the providers to do this more simply and cut down this element of expense?

Secretary Califano. I hope so, Mr. Pike. We are looking at it as part of the general review of the tremendous recordkeeping requirements that HEW imposes on the American people and their institutions, both in health and education. I understand the import of the comments you are making. I would hope we can do something about it.

There has to be more uniformity, more simplicity in the information gathered. There is no question about that.

Mr. Pike. I know by the time you have read your new regulation and signed it, it will be superb. I yield back the balance of my time.

Mr. Rostenkowski. Thank you, Mr. Pike.

Mr. Martin will inquire.

Mr. Martin. No questions, Mr. Chairman.

Mr. Rostenkowski. Mr. Scheuer will inquire.

Mr. Scheuer. It is a great pleasure to have you here, Mr. Secretary.

It is a pleasure to participate in this first and historic meeting of our two subcommittees working together and I wish to congratulate the two Chairman for their forthcoming attitude. It gives me great hope that we will be able to meet the problems of health care legislation in a very intelligent, effective way.

One of the problems that the States have had in dealing with fraud and abuse is that it is an expensive matter both in detection and investigation as well as prosecution. In a State like New York, where both the city and the State are in a condition of financial extremism, it has been impossible for them to devote adequate resources to the problem of fraud and abuse detection.

I had a day of hearings last year representing the Oversight and Investigation Subcommittee of the Interstate and Foreign Commerce Committee on medicaid fraud and abuse. We held the hearing in New York City. The witnesses subsequently said they would like to do more, but simply don't have the resources. I am introducing an amendment to H.R. 3 that says that any State that sets up an independent free-standing investigation and prosecuting agency devoted to investigating fraud and abuse in medicaid and medicare, and where there's a maintenance of effort of all other prosecuting efforts, that send an agency would get 90 percent funding for the first 3 years and 75 percent funding thereafter for its operating expenditures.

This approach has been supported by the attorneys general and was supported by the Governors in their meeting with President Carter. Any bright-thinking person understands that we have to devote intensive efforts to this. The question that bothers the States and the cities is where is the bread going to come from?

Would this general approach that I have outlined make sense to you as an amendment to this legislation. I would be interested in knowing your attitude.

Secretary Califano. Mr. Scheuer, I would like to think about that. Ninety-percent funding with income contributions is in effect a 100-percent funding. Thus, it means the State does not have to make much of a conscious choice as to the use of its resources.

The other thing to which thought must be given—and I am speculating—is the distinction between the kinds of support we give to the States for nonpolice activities, if you will, as contrasted with support we give for police activities.

I have an intuitive reluctance to providing virtually 100-percent Federal funding of local police forces to ferret out fraud and abuse; in other words, the national police force issue is obvious.

I would really like to think about it and give you an important, informed, and thoughtful response.

Mr. Scheuer. Well, Mr. Secretary, it was negative of me not to have gotten this whole package to you before this. I apologize for it. I will send it on to you.

Perhaps we could leave the record open for some kind of expression from the Secretary.

Mr. ROSTENKOWSKI. Without objection, so ordered.

[The information follows:]

The Department wishes to encourage States in combating fraud and abuse. However, the Department has doubts about creating State fraud and abuse units separate from the Medicaid program, and, further, we resist financing in the amount of 90 percent. States should be asked to make a larger investment in the enterprise.

Mr. SCHEUER. Also the numbers in a sense—perhaps only a small number of people who are sophisticated in computer techniques and investigation could do a great deal to spotlight fraud and abuse in these programs. It may not—the kind of effort this committee wants, the kind of effort that you want, may not require the large numbers of people that a less-sophisticated effort would require.

Mr. WALGREN. Thank you.

Mr. SCHEUER [presiding]. Mr. Secretary, I have been asked to take the Chair temporarily.

Before recognizing Mr. Maguire I am going to attempt to assuage your doubts on the question of a Federal police force. This was the furthest thing from our minds.

Secretary CALIFANO. I know that. We have known each other well for a long time.

Mr. SCHEUER. It would be as anathema to me as it would be to you. I am only mentioning that because you talk about the sophisticated use of the computer. What we are trying to do is set up a very sophisticated group of professionals who have been trained and experienced in tracking the illegal activities of a minute portion of our society, the providers—and a minute portion of the providers. It will be a very finely tuned, very sophisticated group using elaborate computer techniques and so forth to zero in on a very, very, very tiny element in our society; and it would be the furthest thing in the world from any kind of incremental approach to the concept of a Federal police force.

Secretary CALIFANO. Let me say, for the record that I certainly know your representation to be true. I know that, first-hand, furthermore, from a personal sense and also from reading and watching the level of your commitment to individual rights. That sensitivity is very special and unique in this Congress. I in no way meant to imply anything otherwise.

Mr. SCHEUER. I just wanted to clarify the record. I would ask unanimous consent for this colloquy to be placed immediately following the formal colloquy that I had with the Secretary when I was asking questions during the 5-minute rule.

There being no objection, so ordered.

I yield back the balance of my time.

Mr. Waxman will inquire.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. Secretary, I too am delighted to be with you at this first meeting and look forward to a close working relationship. It's been a frustration, I have to say quite frankly, working with the two previous Secretaries because I didn't feel their commitment was the same that you and I share.

I want to ask you a question about the fact that I see so often in Government passage of laws with one set of intentions, one set of results and the effect of it is to have a consequence completely contrary to what the Congress and the administration hoped.

For example, many of the physicians are refusing to take medicaid patients. They claim that there's too much redtape, too many papers to file, not enough fees paid to them under the medicaid programs compared to what they get in private practice and a number of medicaid recipients, therefore, are without the ability to have access to a health care system. If we pass a bill such as this, are we going to have a further effect of that possibility of fewer medicaid patients having access to the health care system; and, second, while it's a collateral point, is the Department looking into that whole question of making sure that medicaid recipients will be able to see a physician if necessary, and then the health care system will be available to them?

Secretary CALIFANO. I think that we can do better in terms of administering programs in connection with the burdens that we place on people, in terms of their having to write papers, fill out forms, or making programs so burdensome that the individuals do not want to be involved in them.

We are and will continue to be looking at that issue.

As for this legislation, it is our objective to find ways to enforce it but not create that kind of problem. Similarly, it is our function to find ways to work with State task forces of the kind Mr. Scheuer has mentioned which can be so helpful in these areas.

I would hope that we wouldn't put another massive administrative burden on everyone concerned lest we drive people away from medicaid. So we will do our best.

Mr. WAXMAN. One of the problems that some of us encountered with your predecessor, Secretary Matthews, which perhaps resulted in my saying—making the comment I made earlier—was the question of utilization review programs at the State level which would make sure that we know how the money is being spent for the medicaid program, whether the programs are being set up by the State to monitor fraud and abuse an monitor the unnecessary services that might be provided all at the taxpayers' expense. The law now provides that the Secretary must cut back on the amount of medicaid money to—from HEW to the States if they haven't provided you with the utilization review programs.

Have you had an opportunity to review that and do you have any plans to take action?

Secretary CALIFANO. I have not had an opportunity to get an informed sense of what kind of action should be taken. I would note in a related area; namely, health care for children, that when we looked at the EPSDT program, our sense was that penalties did appear to not work effectively. States would rather absorb that penalty than ferret out and find the disadvantaged children, or so it would appear.

We prepared a major change in the Carter administration budget; and we will be proposing a legislative change that will go to your committees which would increase the Federal share to 75 percent.

On the whole, I am not saying anything about our ability to get something done by imposing penalties. They seem to lead to litigation, long years in court and little getting done. But I haven't made any specific decisions with respect to the program you have mentioned. It is a serious problem. There is no question about that. It is under examination.

Mr. WAXMAN. Thank you very much.

Thank you, Mr. Chairman.

Mr. SCHEUER. Mr. Skubitz will inquire.

Mr. SKUBITZ. Thank you, Mr. Chairman.

Mr. Secretary, I am new on the committee. Maybe my questions may appear rather elementary to you.

Secretary CALIFANO. They won't be elementary to me.

Mr. SKUBITZ. No. 1, the medicare program is paid for under the Social Security Act; is this correct? The medicaid is for what we classified as welfare cases?

Secretary CALIFANO. Well, medically-indigent people.

Mr. SKUBITZ. Well, that is how you say it.

Secretary CALIFANO. The aged, blind, and totally disabled are the AFDC recipients.

Mr. SKUBITZ. In the case of medicare, are those records, are the charges made by doctors available to the public or not?

Secretary CALIFANO. My understanding is that under the Sunshine Act much of that information will eventually become available to the public. However, there is probably a good chance that litigation will precede final resolution of the issue.

Mr. SKUBITZ. The records are available in case of the welfare cases; isn't this correct?

Secretary CALIFANO. In the medicaid area there are more records available.

Mr. SKUBITZ. You expressed strong support for this legislation. Am I to understand that when we have charges as you have indicated in your testimony that you have no authority to act now under the law?

Secretary CALIFANO. No. I am not saying that, Mr. Skuwbitz. We are examining those cases and where there appears to be criminal activity, we will turn those cases over to the Department of Justice. This legislation would provide additional authority and technique to reach further than we have been able to do.

Mr. SKUBITZ. But you do have the authority today to act, do you not?

Secretary CALIFANO. We have considerable authority. If someone defrauds the Government in some way, we would, if we have appropriate evidence, turn the case over to the Department of Justice for action.

Mr. SKUBITZ. Let's take the case on page 3, a payment for comprehensive examination amounted to $155,000 of that physician's total medicaid bill of $220,000. Was that turned over to the Justice Department?

Secretary CALIFANO. No, not yet. That is a case that we have just come across recently. It is being studied.

Mr. SKUBITZ. Do you have a record of how many cases were turned over by the outgoing administration?

Secretary CALIFANO. I can supply that for the record.

Mr. SKUBITZ. I ask unanimous consent, Mr. Chairman, that the Secretary provide for the record the number of cases that were turned over; and if he can, the number of actions that were filed, and of that, how many were prosecuted and how many convictions we have.

Mr. SCHEUER. Without objection, so ordered.

[The information follows]:

OFFICE OF INVESTIGATIONS

	Fiscal year 1974	Fiscal year 1975	Fiscal year 1976
Cases to Justice	(1)	23	23
Indictments	1	12	23
Prosecutions	1	3	3
Convictions	1	4	[2] 38

[1] 74 Statistics System did not contain this information.

[2] More than 1 individual named on some indictments. Majority of defendants pleaded guilty; therefore, no trial was necessary.

Mr. SKUBITZ. That is all, Mr. Chairman.

Thank you, Mr. Secretary.

Mr. ROGERS. Would it be proper to make just one comment?

I think one of the points of the legislation is that we are increasing the penalty so that it is clear it really means something.

Mr. SKUBITZ. Well, will the gentleman yield?

Mr. ROGERS. Yes.

Mr. SKUBITZ. I think if we would spotlight to the public perhaps the names and the amounts that are being paid, that would probably have as much effect as increasing the penalties from misdemeanors to felonies.

Mr. ROGERS. I agree it would be helpful. Hopefully when the penalty is an effective deterrent, they will be made public.

Mr. SCHEUER. Mr. Vanik will inquire.

Mr. VANIK. Mr. Secretary, during the last Congress I was the Chairman of the Ways and Means Oversight Committee. We found several instances where the intermediaries and carriers were not doing their job. Audits were perfunctory. There were cozy relationships between intermediary auditors and providers being audited. I am aware of at least several cases where the provider seems to have made a habit of hiring people from the intermediary who have been auditing the provider. In some cases, the remuneration appears to have begun prior to the intermediary auditor leaving the intermediary.

Now at an appropriate time, I would like to offer an amendment which would restrict for a few years intermediary personnel from taking jobs with providers they have been auditing. What would be your reaction to this kind of an amendment?

Secretary CALIFANO. Mr. Vanik, I would like the opportunity to review the specific of your proposal and to think the total implications of such a problem through. I will give you an informed answer about it. Obviously, it is important in any free system—and ours is a free system—to avoid every conflict of interest and to avoid corruption at any level of the system, whether it be private or public or another level of the system.

I understand the point of your amendment. I would like a chance to look at it and give you a specific response. I am very well aware of all the work that you have done in this area.

Mr. VANIK. I have another concern. We have just gone through a soul-searching trial in the House on our own disclosure and conflict of interest arrangements; and the legislation that has now been enacted to try to express itself to the problem. Do you have financial statements from VHI and medicaid officials?

Secretary CALIFANO. I have not personally looked at such statements. We are looking, in a very broad way, as to the levels to which the kinds of disclosures that the President has imposed upon his appointees should be applied, the type of information that should be filed with the Civil Service Commission. As soon as I have a general counsel formally appointed, we intend to look at the whole arena in HEW.

Our focus will go beyond the medicaid and medicare. The General Accounting Office has reviewed FDA and has found serious weaknesses in its system. There is no question but that we have to strengthen the disclosure and the conflict possibilities in this Department as in other departments.

At the same time, we have to be careful in how we do that. It is not any easier now to attract highly talented people to the government than it has been in the past.

Mr. VANIK. Well, what would be your opinion of a VHI or medicaid official who takes consulting fees and travel reimbursement from providers who deal within an official capacity?

Secretary CALIFANO. In the abstract, obviously I don't think that should be done.

If a man was paid a travel expense to speak before an association or something like that, I can conceive of cases in which it wouldn't instantly be improper.

Mr. PIKE. Would the gentleman yield?

Mr. VANIK. I would certainly yield.

Mr. PIKE. You might limit it to 15 percent of the salary. [Laughter.]

Mr. VANIK. That might be one way of handling it.

This is a serious matter.

Secretary CALIFANO. Obviously there should be action—at this point in our time, in our country and in view of what has happened in the National Government in the last 8 years. Obviously it is imperative that we act, and that the people entrusted with public funds and programs act impeccably.

In that connection, I am in complete sympathy.

Mr. VANIK. I have spent a long time in public service. As I look at the Federal structure, if anybody wants to operate, the easiest way to do it is quietly inside the bureaucracy. I think the most hazardous route for anyone wanting to get something is to do it through Congress. I would just hope that in the application of regulations and disclosure that we can help curb the actions of those who use their offices for getting a permanent job later on or moving into more bountiful pastures.

I think frankly what we ought to try to encourage in public life is a dedication to a service over the long term.

Thank you very much.

Mr. SCHEUER. Mrs. Keys will inquire.

Mrs. KEYS. Thank you, Mr. Chairman.

Mr. Secretary, I have a question. I hope you can answer it. It seems to me that PSROs are limited in their effectiveness, their ability to set standards, review, et cetera by one missing component; and it becomes——

Mr. SCHEUER. Would you yield for a second.

The Chair would like to make an announcement: It is the intention of the Chair to work through lunch, to retire for a few minutes to answer a quorum call, but it is the Chair's intention to work through lunch.

Mrs. KEYS. That missing component is very important. As we seek to enlarge and depend more heavily on them, it becomes more important that it be legislatively corrected. That is the inclusion of nurses in PSRO's.

I wonder if you, Mr. Secretary, would support the legislative correction of the establisment of PSRO's to include nurses.

Secretary CALIFANO. I have to ask you in what way? To have nurses review doctors, or nurses review nurses, or nurses review hospitals?

Mrs. KEYS. To include nurses as part in PSRO's to review the whole—all the elements of health care. There's nothing more important to the successful illness or wellness treatment whether in a hospital or a doctor's office than the successful performance of the responsibilities of the nurse, whether on their own or serving as a physician's assistant that is under direct supervision.

Secretary CALIFANO. This is the first time that that question has been put to me.

I would like a chance to think it through. I will give you a direct answer on that question as soon as I have done that.

Mrs. KEYS. Thank you, Mr. Secretary. I will rely on that.

There has been legislation introduced with a great number of cosponsors. It seems to me it is a direction we ought to move to make PSRO's more effective.

Secretary CALIFANO. Thank you, Mrs. Keys.

Mr. SCHEUER. Mr. Gradison will inquire.

Mr. GRADISON. Mr. Secretary, I certainly value your testimony. I hope out of this legislation it will be possible to close down many of the so-called medicaid mills. In the process, it is possible that many innercity poor people who are now served perhaps inadequately but served by these shared health facilities may be left without the care that they have been receiving. I wonder what positive steps you may have in mind as alternatives to provide care to those who are now being served by some of these outfits that we hope will be closed down?

Secretary CALIFANO. The first step would be to provide the encouragement to responsible organizations to move into the inner cities to replace the mills. The mills do not provide reasonable treatment. Our administration promotes continued and enhanced funding for the National Health Service Corps program, to which I am strongly committed, to encourage doctors to go into inner cities and rural areas. We also have proposed to extend medicare to cover payment for nurses and paramedical clinics in underserved areas.

While most people think of that in terms of rural areas, the way we would define underserved areas would also include inner cities.

We are aware of the problem you pose.

Finally, if we increase the amount of money for identification of students, including minorities, at a relatively early age—high school or early college—and finance them through the professional schools to join the paralegals of the country, hopefully some of those individuals will return to some of the areas in the inner city.

Mr. **Gradison**. I have had a chance to sit through the hearings at which your representatives have spoken about extending into urban areas the physician extender programs. It makes a lot of sense to me.

One final question, Mr. Chairman. This relates in part to a question that was asked earlier by Mr. Waxman with regard to the loss of participating physicians from these programs. I think in some respects this is directly related to what we are talking about here today in that there have been some physicians who have built up a major part of their practice around medicaid activities, and others who don't participate much at all. There have been suggestions made very recently that doctors should be required to participate in the medicare-medicaid programs, perhaps as a condition for their ability to use certain publicly supported hospitals in carrying out of their medical practice.

Do you have any thoughts on that subject at this time?

Secretary **Califano**. I do not at this time have any thoughts on that subject, but we will as time goes on.

Mr. **Gradison**. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

Mr. **Scheuer**. Mr. Walgren will inquire.

Mr. **Walgren**. I am just sitting here thinking what my people would like me to add at this point in this kind of a hearing. I really want to encourage you from them on the adventure you are about to embark on. There is no way that you could underestimate its importance. You are only dealing with $40 billion of Government money, but you are dealing with the bitterness that our people are feeling when that money is misspent.

Although it is true that the abusers prey on the poor and the sick, they also prey on the public. That is public money.

You are probably right at the core of the ethic in our society that it may be all right to steal money that is public because it doesn't belong to anybody. So the extent to which you succeed is not only going to set the moral tone for society to a large extent. I had another thought which was that you say that this—the success of this program will be an essential building block towards a comprehensive medical program for our people; and the corollary to that is that we won't have a comprehensive medical program for our people until we succeed with this kind of a program, because of the kinds of costs that are involved in paying for a comprehensive medical program.

So there is no way that I could do anything but wish you godspeed in this effort.

One thought I did have in terms of raising a question: We presently now have, according to your testimony, some 300 people involved in the investigation in HEW on a $40 billion program; that would work out to around $13 million apiece. Is there any systematic approach that you are taking towards deciding how much of an effort should be made in that area? What is the reasonable amount of that kind of expenditure to be looked at by a given individual?

Secretary CALIFANO. Mr. Walgren, we have requested, in the fiscal 1977 budget, additional funds for additional investigators. When the Office of Inspector General is formally established it immediately and automatically will receive 1,000 auditors from our comptroller's office and the entire investigation office.

I am virtually certain that we will be coming to the Congress after a few months of experience with the Inspector General's Office asking for additional assistance of one kind or another. I don't think I can intelligently tell you what that assistance should be at this time.

Mr. MAGUIRE. Let me join in welcoming you. I am confident that you will go down in history as the first Secretary of HEW to have achieved full control over HEW and its many programs. I also hope that you will lead us to some decisions with respect to what I believe is desperately needed: a national health insurance program and toward delivery of quality health care to all Americans. I was very pleased to hear your response to Chairman Rogers' inquiry about uniform accounting principles and systems. I think we have a hodgepodge and we desperately need that kind of approach if we are going to have better management, simplified auditing procedures, lower costs, and better results.

In turning to this piece of legislation, I would note, as others have in various ways, that it relies rather considerably on PSRO's. PSRO's, I think it would be fair to say, are still in their infancy or at least in their early experimental stages. There have been questions—I think it would be fair to say—and I am sure all parties would agree to this—that there continue to be some questions about how effective and competent at least some PSRO's are or have been; and in that connection, I want to observe that there are a number of States—not very many, but a number, of which my State of New Jersey is one—which have mounted fairly effective fraud and abuse detection and control and prosecution programs. In an effort to reducing duplicative review processes, I think there is a thrust in the bill to give PSRO's exclusive jurisdiction. Yet, I wonder in terms of the expense in some States, and laying that over against the questions about the expense of PSRO's, at least in the near future, whether you have any plans or intentions to build upon and ensure that those States like New Jersey and a number of others which currently have relatively sophisticated cost-control mechanisms in place might not be set aside prematurely?

Do you envisage building upon those State capabilities for which you see the PSRO mechanism, for whatever reasons, uniformly, simplicity, what have you, nationwide, being the exclusive mechanism? How would your answer to my question relate to your feelings about this particular bill and how it has been drafted?

Secretary CALIFANO. Let me just say as a general proposition, that I think the problems of health care costs and health care utilization are so difficult that they will require a whole variety of tools for solution.

I have not sensed that it was the unyielding desire of this legislation to make the PSRO the exclusive tool to use to deal with these problems. I did sense from my reading of the legislation that there was a desire to expand the PSRO so that where it is operating effectively and as it does reach its full potential, it can move out into other health care areas such as shared health facilities.

I think that in cases where States are doing well, we ought to make provision, to the extent we can, for States to continue to do well; and all I can really give you are the general principles. I am reluctant to get into the specific language at this point.

Mr. MAGUIRE. Of course, if we might have further consultations with you, as I am sure we will on language, I think the kinds of issues we are dealing with are whether there should be permissive language for States to participate in the review provisions of the program. Additional issues include, for example, whether States should be able to contract with PSRO's and therefore maintain some greater role than if they were completely out of the picture, and whether or not in fact if you extend a conditional status of a PSRO, when admittedly the PSRO has not yet achieved its full status, which is provided for in the bill, whether States are actually going to be precluded in the meantime.

I hope these are some of the things we can work on.

Secretary CALIFANO. I am sensitive to your concerns there. The whole issue of hospital cost containment is an example. There are States—Massachusetts is an example—which have on their own managed to reduce hospital rate increases to about 9 percent a year.

In short, there are many areas in this arena in which the States are indeed ahead of the Federal Government. I am sensitive to that.

Mr. MAGUIRE. I thank you for that statement.

Mr. ROSTENKOWSKI [presiding]. Mr. Martin will inquire.

Mr. MARTIN. Mr. Secretary, most of the materials in the amendments we are considering, and the discussion so far, have dealt with the standards that are to be enforced and that are to be tightened up with regard to operation of health care services, which are eligible for medicare and medicaid and also with regard to the penalties that would result from violation of these standards. There is also some concern about the adequacy of the enforcement procedures that we have, the personnel, the existence of units which would deal precisely with these kinds of matters; and I would like to have a little bit more of your thinking in that regard; for example, whether as some have suggested, we should have a requirement that in order for a State to be eligible for these programs, that they would have to establish a special unit to investigate health-related fraud with prosecutorial powers in that unit, for the same kind of unit to be established in the Justice Department with sperial assistants for each of the U.S. attorneys who could deal with this matter who would be trained in this mystique, let's say, of health care agencies?

Secretary CALIFANO. Mr. Martin, I will leave the decision as to how that effort should be organized to Attorney General Bell.

Mr. MARTIN. Your Department does not have an opinion with regard to——

Secretary CALIFANO. As far as the States are concerned, I have always had grave reservations about special prosecutors for this, or special prosecutors for that, being established on any continuing permanent basis.

I say that as a lawyer; and I say this personally. I have grave reservations about the Federal Government imposing a requirement for some kind of permanent special prosecutor on a State and imposing on a State the requirement that it vest that special prosecutor with special authority. My hunch would be—and I speak here as a citizen as much as anything else—that there are probably some very difficult questions, legal and constitutional about the power of the national Government to do that in the criminal justice system.

Mr. MARTIN. The power to require that they have such an agency in order to qualify for the funds?

Secretary CALIFANO. To require a State to set up a special prosecutor on a permanent basis with subpoena power and various types of authority to prosecute. I am not sure under our system of government that power resides at the national level.

Mr. MARTIN. There may be some question about just a priori requiring a State to do such a thing. What about requiring it as a condition for eligibility for these funds? Perhaps also tied with that, a commitment of Federal money for the establishment initially of the program and for higher percentage of sharing in the costs of that prosecutorial unit during those first few years when you are having to deal with a backlog of cases? There I am presuming once you establish, you mean business, that the number of cases will fall off and the expense might not be quite as high.

Initially, it will be extraordinarily high. We have had examples in the news accounts of some States that have been spending millions of dollars on such agencies but reaping many more millions in return in the criminal penalties that they have been able to assess?

Secretary CALIFANO. Mr. Martin, I would much prefer to leave that up to the governor of the State. I would not be inclined to condition Federal funds on forcing the governor of a State to set up a prosecutorial unit to deal with this item or that item, or to give that unit certain specified powers. My instinct would be to let the governor decide how he wants to deal with such a problem. I think you can probably get a more officially informed view from the Department of Justice on that particular kind of amendment to this legislation.

I just give you my personal view, if you will.

Mr. MARTIN. Let me ask you one more personal view which would not require you to advise anybody else how to proceed, either the governor or the Attorney General. That is in your personal view, is the law enforcement system with regard to health care abuse adequate?

Secretary CALIFANO. I have to say that on the basis of the anectdotal evidence—and it is not systematic evidence available—it is not adequate, but I think there is a lot more that can be done at the Federal level.

I think there is a lot more that can be done in the Congress in terms of the kind of legislation that these two subcommittees are now considering; and perhaps in the kind of thing that Mr. Scheuer is suggesting. I do not think it is adequate either administratively or legislatively. I think that is what we are about here today. I was giving you my personal views on one piece of an amendment you are discussing.

Mr. MARTIN. You are saying not only are the laws themselves not adequate, but you are saying in addition, in your opinion, the enforcement system is not adequate?

Secretary CALIFANO. I think we can do better, and I think as more and more States are beginning to move in more and more different ways, they can probably do better. I think you will hear from some witnesses today, such as Mr. Skinner and Mr. Hynes, who will give you a sense of a view from the front lines and give you a better sense of that.

Mr. MARTIN. In your opinion, the enforcement system is not adequate at this point?

Secretary CALIFANO. I am willing to say that, and that it can be improved. I also want to reiterate that I do not think it is the function of the National Government to impose upon governors a requirement that they establish a permanent special prosecutor and give them a lot of police authority if you will, and prosecutorial authority, to deal with any specific area of an activity.

I think it is something that the National Government should think very seriously about before stepping into. I think it is fraught with danger in constitutional terms and in terms of Federal-State relations and indeed maybe civil rights values.

Mr. MARTIN. Mr. Chairman, I know my time is up. I would want to say that while it is not the business of these committees which are hearing this particular subject, that this does open an interesting avenue of conversation, perhaps, for some other time with regard to whether it will be the intention of the administration to pursue that same standard of allowing executive leeway to the governors with regard to public education.

Mr. ROSTENKOWSKI. Mr. Scheuer?

Mr. SCHEUER. Just to clarify the doubt that you raised. Mr. Chairman, I agree a mandatory program would raise grave questions in my mind. The program I am suggesting is entirely voluntary. If States choose to do A, B, and C; then the following Federal benefits will be made.

It would be totally a voluntary program.

Mr. ROSTENKOWSKI. If there are no further questions, thank you.

Mr. Markey?

Mr. MARKEY. Mr. Secretary, what would the expenditures be using a private insurance plan such as Blue Cross to help audit medicaid claims?

Secretary CALIFANO. Some of the auditing? Have private health organization do some of the auditing in the medicaid area?

Well, I think everyone along the way is going to have to perform some of the functions. If you mean legislative authority, I think that should be given to the Department of Health, Education, and Welfare.

Mr. Markey. Do you intend to utilize private providers who maybe have more expertise in this type of oversight?

Secretary Califano. I would think that I would like to look at that as part of a program to deal more effectively with this problem. I cannot answer that specifically and directly right now.

Mr. Markey. Thank you.

Mr. Rostenkowski. Mr. Secretary, we certainly appreciate your appearance here. It has been most valuable. I am sure you will find a great deal of cooperation on both sides of the aisles.

Secretary Califano. Mr. Chairman, thank you very much.

Mr. Rostenkowski. Mr. Skinner.

STATEMENT OF SAMUEL K. SKINNER, U.S. ATTORNEY, NORTHERN DISTRICT OF ILLINOIS, ACCOMPANIED BY ANN TIGHE, ASSISTANT U.S. ATTORNEY; AND WILLIAM ELSBURY, ASSISTANT U.S. ATTORNEY

Mr. Rostenkowski. Mr. Skinner, welcome to the committee. I am sure I speak on behalf of Mr. Rogers and the Interstate and Foreign Commerce Committee. We are happy that you have come to Washington this morning to give us the benefit of some of the experiences you have in this area. I certainly have known of your reputation, being a citizen of the northern district that you represent. We are quite proud of the fact that you have been such a courageous and outstanding worker in the field in this area.

If you would like at this time to identify yourself, your associates, and proceed with your testimony, the committee is ready to receive it.

Mr. Skinner. Thank you, Congressman Rostenkowski, Congressman Rogers.

I have with me today two of the people that have been performing in the area of prosecution of cases in the medicaid and medicare area for a number of years. One of whom is a constituent of yours, Congressman Rostenkowski; on my left, Assistant U.S. Attorney Ann Tighe, Chief of the Government Fraud Unit in our office.

On my right, William Elsbury, the Deputy Chief of the Governmental Fraud Unit, who was the lead prosecutor in our cases involving nursing homes recently where a number of people were incarcerated and well over $1 million in fines were asssessed in one case alone.

I would like to make some brief comments. Recognizing it is a long schedule and a number of members of the committee may have some questions, I will try to save as much time as I can for questions, Congresman Rogers and Congressman Rostenkowski.

I would make some observations as a prosecutor of 9 years that I think are important for us to keep in mind. Number one, the taxpayers in this country have accepted these programs in the true sense of a democracy. I am surprised and frankly pleased that the American taxpayer has been willing to allocate the amount of dollars through you to these programs that he has.

I am also surprised that he has accepted the problems that exist in these programs in these areas for so long.

In my opinion—and I hold myself partially responsible as well—we and members of the administration, the executive branch in Government, in Congress, have not done our share in assisting the taxpayer in getting what he expects from these programs in delivering what is expected as far as good care in a fraud-free and well-managed program.

The problem in medicaid and medicare fraud areas is serious. I don't care whether you are from Kansas, Congresswoman Keys, or from Ohio, or California, I don't think we know how serious the problems are. We had no idea 2 years ago when I set up the first governmental fraud unit of its kind in the country what we were getting into. I started with four lawyers I really couldn't spare. I now have 10. I have at least two squads of FBI agents and three grand juries sitting full-time working on my problems alone. My inventory is about 14-pages thick of cases that we have developed on our own without even referrals from HEW or other agencies.

I suggest that when other prosecutors and other investigators involve themselves in this problem in your States, they will find similar problems, maybe not as great, hopefully not as great, but certainly significant.

I also would like to mention that at the same time you are asking prosecutors to take very vigorous efforts in the area of prosecuting these cases, there is a strong movement in Congress for grand jury reform and tax reform that will limit substantially the ability of prosecutors to do their jobs; and it is ironic that the same people that share as I do the concern for health care for millions of Americans and a well-run program, are also pushing for grand jury reform and tax reform that will limit our ability to perform; and I suggest as you balance those interests, we should keep both of them in mind.

I would also remind you that there's no replacement for this care, if the taxpayers revolt and decide to either send people to Congress or demand of you as constituents that the programs be cut back or abolished. I think the time is coming that if we don't take action, that is exactly what is going to happen.

Senator Moss over 5 years ago held hearings in the Senate on problems in nursing homes and in the medicaid and medicare areas. Unfortunately, very few prosecutions if any and very few steps by the administration were taken after those exposures were made and those investigations were put forth.

Only recently have steps been taken by the administration, Secretary Califano is off to a good start. He has a most difficult job. I recognize from reading in the newspaper he was very successful in the private practice of law. I hope he is as successful in managing HEW.

Why haven't we done anything? Why in the world 5 years later are we still dealing with these problems and finally reacting to something that has existed for years?

Well, I suggest we are all responsible. We all didn't read enough. We all didn't pay enough attention; and I am glad to see that for the first time my knowledge anyway—and I am not a resident of Washington as you know—that two committees of Congress put aside traditional jurisdictional disputes and jeolousies and work together, because it is a problem that will require the energies of all of us whether we be from Indiana, from Illinois, from California, New York, or North Carolina.

I am not going to spend a lot of time on dealing with the problems that exist. In Illinois, I think we have as good a cross-section of medicaid and medicare fraud as any place in the country. In my statement I have listed a number of situations that we have found. The ones that Secretary Califano talked about this morning in my opinion are minor compared to some of the problems that exist throughout this country. I know the committee staff has met with our people in Chicago. They were well aware of the problems. We are well aware of your interest and will meet with you at any time.

I do want to take a minute to discuss several recommendations in my statement that I think are important as you consider this bill. First of all, H.R. 3 is a good step forward and I recommend that after serious consideration of all of the factors and all of the concerns of the Department of Justice and HEW, that some program be implemented along the lines of H.R. 3. It is a good step. It is only a step.

We are not going to eliminate this problem by legislation and we are not going to eliminate it by a few more prosecutors. We have got to administer these programs properly from the beginning. We cannot start to spend 1 billion or 2 billion without any test-marketing or any standards or any personnel or people in place to administer the programs.

I had the opportunity for a number of years to work for a very large corporation; and they wouldn't think of implementing a program of this magnitude without standardization, without a gradual phase-in, and without test-marketing.

Now, after my testimony recently before the Senate, a number of people indicated they felt I was against national health insurance. I am not against national health insurance and I am not against the benefits these programs offer. I think I am a representative taxpayer who is willing to share his resources with others, but I want it done on an equitable basis, on a well-managed, reasonable basis. I don't think by rushing into any program without proper control and without proper oversight by Congress, we can implement programs that are going to be successful; and what will happen is either the taxpayer will turn off or more importantly, we will so destroy the moral fiber of a community that is entitled to these benefits by the observations they make as to how these programs are administered and managed that these people will become totally disenchanted with the American way of life.

One of the problems that appears to be of major concern in the area of medicaid fraud is the use of factors or billing services. H.R. 3 deals with these problems. We have suggested to the committee in my prepared statement that as a part of this amendment, it be clear that moneys should be paid by the organization that is making the payment directly to the individual who certifies that he has rendered the medical services, rather than making the payment to the provider who then will have the responsibility for turning it back to the individual practitioner.

A number of doctors came to me after HEW released their list of major expenses or major beneficiaries of provider services and payments in Illinois and said, "I don't care what the list says, I use a factoring service and I didn't get that kind of money."

If we allow the factoring service to provide the preparation and the forwarding of the bills, but we insist that the provider who certifies that the services were provided receive copies of invoices and receive copies of the bills and the payment and the checks, I think we are going to place a great deal of responsibility on the provider and make them alert to what the factor is doing.

I think that this should be mandatory.

A second area which we are very concerned about and which we are very familiar with in Illinois is in the area of mandatory disclosure of ownership. We found in Illinois, for instance, that seven nursing homeowners owned and operated over 20 nursing homes, each of them had a small interest, relatively speaking, but together they controlled over 20 nursing homes in the Chicago area.

The only way we are going to know whether or not there are sweetheart arrangements between nursing homes, between clinics, between providers, between druggists, is if we have full disclosure of ownership by nursing home operators as part of the program requiring certification.

I think—and this should be direct as well as indirect ownership—nominees should also be disclosed. I think that if people are going to do business in this area, and provide health care, and have the responsibility for caring for hundreds of thousands of Americans, they at least should acknowledge to the public what organizations they are associated with and what other groups they are working with.

I have listed a number of mandatory disclosure items in my statement which I would hope the committee would institute as part of H.R. 3.

Finally, the third provision and suggested change which we are very concerned about is section 4. Section 4 would upgrade the criminal penalties for fraudulent activities in the medicare-medicaid area to felonies. We agree with this. We think the penalties are not strong enough. We think they do not serve as a substantial deterrent to others in this area. We do suggest, however, that the misdemeanor provisions be retained. This gives prosecutors additional flexibility in prosecuting cases, in obtaining cooperation with pleas of guilty to misdemeanors as well as using immunity; and at the same time, it allows us to prosecute aggravated cases with felony prosecutions.

I might add that there is not a great deal of experience in the use of the misdemeanor statute. We were the first office in the country in one particular area to ever prosecute a case under that statute. It only had been in existence about 4 years.

Finally, we asked in our statement, in our contact with the staff, for more specific definitions of the words "kickback," "bribe," of "rebate." They have become very sophisticated in the health care field. They know what cases we are prosecuting. They are now using their ingenuity in an attempt to get around us. Through our suggestions we hope we can stay ahead of them and stay ahead of the game.

Members of my staff such as Bill and Ann, who have spent all of their time for the last years working on this problem are quite concerned that everybody recognized just how serious it is and expressed to me as we were listening to Secretary Califano their concern that we not do a superficial or facial job, and say when we pass H.R. 3, "it is done." It demands oversight, it demands review; it demands a lot of resources to be implemented and put into the area.

When you talk about the expenditures of HEW in Illinois alone, we spent over $2 billion in the Northern district for health care programs. We can afford to spend some resources in the area of audit and control. The Office of Inspector General is a good step forward. Additional prosecutors are needed. Additional personnel within State agencies are needed.

I happen to believe that we should, Congressman Martin, have some type of mandatory requirement of investigative or fraud units within a State so that they will work on this problem. Task forces in the Department of Justice are beginning to materialize throughout the country. I think there is an awareness within that Department over the last year about the seriousness of this problem. We can't do it alone. The State government and the State agencies have a great deal of jurisdiction and responsibility in this area; and we should give them incentives whether they be monetary or otherwise to get involved themselves in dealing with what I consider to be a very serious problem.

With that, Congressman Rostenkowski, and Congressman Rogers, I would be more than glad to entertain questions from the committee about what we have done in Chicago and what we have learned from talking to prosecutors throughout the country who have come to us with their problems, and anything that might seek to—to have view on or help on with our experience that we can give them.

[The prepared statement follows]:

STATEMENT OF SAMUEL K. SKINNER, U.S. ATTORNEY NORTHERN DISTRICT OF ILLINOIS

Over the last ten years, a number of federally funded social welfare programs have been initiated and expanded by Congress. The federal Medicare and Medicaid programs are two of these programs which have become institutions within a very short period of time.

The American taxpayer has come to understand the need for quality medical care for the poor, the aged and the disabled, and has, in true American tradition, accepted the utilization of their tax dollars to underwrite these programs and to raise the quality of care for all Americans.

The American taxpayer performed in the highest tradition of our Republic in paying for these programs. The various branches of state and federal government charged with the responsibility for the their implementation and administration have not performed as laudably, as clearly demonstrated by the rampant fraud and abuse discovered in these programs.

During the past five years, Senator Moss' Committee on Aging discovered and publicized the fraud and abuses which prevailed in some of these health care programs. Despite the reporting of mismanagement and fraud within the Medicare and Medicaid programs, Congress and the Department of Health, Education and Welfare have failed to take adequate steps to prevent the misuse of tax dollars. Now, although the taxpayers have come to accept the goals of these federal health care programs, they are demanding and have a right to expect that each of their tax dollars will be used to provide quality medical care, rather than for the personal enrichment of certain unscrupulous persons at the expense of the aged and the poor. It is Congress' responsibility to ensure the integrity of the expenditure of every tax dollar.

Lest anyone here be of the opinion that the Medicare and Medicaid programs have been relatively free of fraud and mismanagement, let me correct any such mistaken impression by briefly relating our experience in the Northern District of Illinois. In July of 1975, I stripped other units in my office of four of my most experienced Assistant United States Attorneys to form the nation's first Governmental Frauds Unit. This unit was established as the first phase of an effort to combat what I then believed to be a major fraud problem in the federal and federally funded social welfare agencies, including Medicare-Medicaid fraud. At our request, the Chief Judge impaneled a Special Grand Jury to hear nothing but such cases. I now have ten highly experienced Assistant United States Attorneys working full time on Governmental Fraud and the problem demands more. What appeared to be only a "major" problem one and a half years ago is now more accurately seen as a motherlode of fraud and corruption within Medicaid and Medicare programs.

Moreover, these problems are not only found in the Northern District of Illinois. Inasmuch as our office has been the front runner in such investigations and prosecutions, we have been contacted by state and federal investigators throughout the country for advice and assistance. Through these contacts, we have discovered that massive fraud and corruption in the Medicaid and Medicare programs exist on a nationwide scale.

In order to illustrate the nature and extent of this problem, allow me to turn for a moment to some individual areas of program abuse which have received a great deal of attention in my district. For obvious reasons, I shall not discuss particulars of cases currently under investigation or indictment. As to those cases, I draw no inference or conclusions which are at odds with the presumption of innocence.

A. NURSING HOME EXPERIENCES

Seven nursing home owners and four pharmacies were recently convicted of paying and receiving kickbacks in connection with the providing of pharmaceutical services to Medicaid patients in nursing homes. The pharmacists paid the nursing home owners three to six dollars per public aid patient per month. In other investigations still underway, such alleged kickback payments are paid under the guise of rent, consulting fees, fraudulent credit memos, loans and cash.

Due to the financial pressure placed on the pharmacists, the kickbacks may result in the followig practices:

(1) Hiring of less expensive unlicensed pharmacists to fill prescriptions;

(2) Failure to comply with regulations imposing certain duties on the pharmacist, such as checking patient medication charts to detect administration of incompatible drugs, training nursing home personnel in procedures for dispensing pharmaceuticals, and acting as a consultant to the home;

(3) Requesting and obtaining prescriptions not necessary to the patient's case such as vitamins;

(4) Billing for prescriptions not delivered; and

(5) Substituting less expensive generic drugs for prescribed brand names, but billing the state for the more expensive brand names.

In other words, the payment of the kickback causes the pharmacist to at least cut corners on the quality of the services he performs, if not engage in false billing. The patient or the government, if not both, suffer.

The sentences imposed upon the defendants in the nursing home cases are precedent-setting. Not only were eight of th eleven defendants sentenced to periods of incarceration ranging from 30 to 90 days, but the seven nursing home owners who were charged with receiving a total of $50,000 in kickbacks collectively were fined a total of $1 million. The message: no matter how enticing, the kickback is not worth it.

B. THE CLINIC/LABORATORY EXPERIENCE

In September 1976, as a result of a lengthy investigation, ten indictments were returned by a federal grand jury charging various medical providers, that is, doctors, pharmacists, clinical laboratories, and related officers, shareholders and employees with various violations of federal law. In a 66 count indictment, 13 individuals, including a medical doctor, three registered pharmacists, and executives and employees of 28 medical clinics and pharmacies were charged with conspiracy to defraud the United States and with mail fraud. In addition, three defendants were also charged with conspiracy to solicit and receive kickbacks from clinical laboratories to which laboratory work was referred. Seven defendants were named in RICO (Racketeer Influenced and Corrupt Organizations—18 U.S.C. 1961) counts which charged a pattern of racketeering activity designed to defraud the United States and the State of Illinois out of the fair and honest administration of the Medicaid program. The 28 medical clinics and pharmacies identified in the indictment and which are subject to forfeiture to the United States are located in the more economically depressed areas of the city of Chicago where the great majority of Medicaid recipients reside. These clinics and pharmacies are reported to have grossed in excess of $15 million during the last three fiscal years. The majority of the work handled by these clinics and pharmacies is Medicaid funded.

The indictment charges diverse and imaginative procedures utilized to generate excessive work and commensurate fees. Among the activities alleged in the indictment are:

(a) Generation of a certain monetary amount of laboratory analyses and tests regardless of or in the absence of medical necessity;

(b) Administering a certain number of electrocardiograms and x-rays regardless of or in the absence of medical necessity;

(c) Issuing a certain number of prescriptions regardless of or in the absence of medical necessity;

(d) Directing patients to all doctors and medical specialists regardless of or in the absence of medical necessity;

(e) Ordering additional and unnecessary laboratory tests and analyses without regard to or in the absence of medical necessity;

(f) Forcing and requiring Medicaid patients to submit to blood specimens;

(g) Mislabeling excess specimens from some patients for submisison to laboratories for analyses under names of other patients from whom specimens were not obtained;

(h) Substituting and submitting their own blood specimens, urine specimens and throat cultures for laboratory analyses as the specimens and cultures of Medicaid patients from whom such specimens and cultures had not been obtained;

(i) Prescribing and dispensing no less than a minimum number of drug and nondrug items to Medicaid patients;

(j) Prescribing and dispensing drug and nondrug items for which the Medicaid program provided the greatest compensation;

(k) Prescribing large sizes and quantities of certain drug and nondrug items but dispensing only small sizes and quantities of such items and thereafter billing the State of Illinois for the prescribed but not dispensed sizes and quantities;

(l) Prescribing certain specific drug and nondrug items but dispensing different, less expensive drug and nondrug items, and thereafter billing the State of Illinois for the prescribed but not dispensed items;

(m) Executing prescriptions in blank, in whole or in part, to facilitate the dispensing of drug and nondrug items without regard to medical necessity; and

(n) Prescribing and dispensing drug and nondrug items without regard to medical necessity.

This indictment resulted from a year and a half of grand jury work and lawyers' time, as well as thousands of manhours of effort by agents of the FBI and extensive cooperation by the Illinois Department of Public Aid. Five laboratories and three laboratory owners have already been convicted and sentenced.

C. OTHER IDENTIFIED AREAS OF ABUSE

The wide ranging investigations of the Governmental Frauds Unit have identified a variety of other areas of Medicare-Medicaid fraud. The extent to which corruption exists has not yet been accurately determined in these areas which include the following:

(1) *Optical services.*—Bills submitted to public aid for optical service for entire welfare families when only one family member (if any) is treated. Many optometrists who work for the optical companies now under investigation are paid by the hour. They had not previously been advised of the dollar volume of bills submitted in their name by their employer, a practice that has only recently been corrected by the Illinois Department of Public Aid.

(2) *Dental services.*—Proving fraud and overbilling in this area is extremely difficult because aid recipients must be identified, located, and examined by a dentist and a comparison of their billings and actual dental work made.

(3) *Radiological services.*—Bills are submitted for numerous x-rays for a patient when in fact only one x-ray was taken. One company has allegedly submitted $600,000 in phony bills over a six month period.

(4) *Overbilling by doctors, podiatrists and other health providers for services never rendered.*—The extent of this fraud cannot be accurately determined.

(5) *The sale and distribution of Medicaid numbers to health care providers.*—Once a Medicaid provider receives the Medicaid numbers and names of public aid recipients, he is able to submit bills to the Medicaid program without the knowledge of the Medicaid recipient, without having met the recipient, and without having performed the services billed. Such information is readily available to various providers in that each time a Medicaid recipient appears at a hospital, medical center, or other provider, he must provide this information. Once a provider has this information, he may exchange it with other providers or this information can be collected by various employees of hospitals, medical centers, etc., and sold to other providers. The extent of such abuse is unknown.

One of the major difficulties we encounter in proving cases involving false billing is that the alleged recipient of medical services is often uncertain with respect to what individual or individuals treated him and what treatment he actually received.

The obvious question which Congress must ask itself is: Why is fraud and abuse within the Medicaid and Medicare programs so widespread? Congress and the Executive branch of government, in their eagerness to enact the Medicare and Medicaid programs provided for substantial funding for quality health care, but neglected to establish various internal and external controls which would maximize the health care services derived from each tax dollar spent. For example, Region Five of the DHEW includes the states of Illinois, Indiana, Michigan, Ohio, Wisconsin and Minnesota, and has an annual budget of $21 billion dollars for that Region. Until recently, only one investigator was responsible for the investigation of all fraud and abuse in DHEW programs in the expenditure of this $21 billion in Region Five. Having only one investigator effectively means no control at all.

Generally, private industry test markets a new product or program prior to investing substantial resources and time in a full-scale implementation or commitment to that program or product. Obviously, the purpose of such test marketing is to gather information, to avoid deficiencies and defects and to cut unexpected costs and wastes. What I am suggesting is that when enacting federal social welfare programs, the legislative and executive branches of government should invest tax dollars as industry invests the funds of their stockholders with an eye toward maximizing returns and minimizing costs. More specifically, programs should be implemented on a small-scale within a defined area in order to test each program for quality and cost control and ease of administration.

The Medicare program is a national operation; implementation, administration and enforcement are the same in all 50 states. Medicaid, as you know, is basically a state-administered health care program for the poor and disabled, financed 50 percent by the federal government and 50 percent by each state.

Even though the federal government picks up 50 percent of the costs, each state is responsible for the administration of its own program. The result is 50 different Medicaid programs, only some of which are effective in preventing fraud, abuse and mismanagement. Congress and the Administration, when enacting the Medicaid program, did not require as a condition of receipt of federal monies, that the states implement specific measures to prevent fraud, abuse and mismanagement. Congress should now require that various preventive and concomitant enforcement measures be taken by all states.

Certainly, the bill now under consideration is a step in the right direction and I am pleased to note that Congressman Rostenkowski's Subcommittee on Health, and the Interstate and Foreign Commerce Committee's Subcommittee on Health and the Environment, chaired by Congressman Paul Rogers, have joined together in the effort to curb the abuses now present in the Medicaid and Medicare programs.

Although H.R. 3 is an appropriate response to current abuses, nonetheless, I have several suggestions to make, based on purely practical considerations, to strengthen the bill. My suggested changes are drawn from the experiences of my staff in investigating and prosecuting Medicaid and Medicare fraud.

The first change concerns Section 2 entitled "Prohibition Against Assignment by Physicians and Others of Claims for Services." The purpose of this section is to prohibit the use of factors and/or billing services by various medical providers, that is, physicians, laboratories, clinics, nursing homes, etc. Basically, a factor prepares and submits a bill for the provider and in effect purchases the provider's claims at a discount. The factor has served to insulate the provider from the actual bills submitted to Medicaid; the doctor assigns his claims to the factor and the factor reimburses the provider for a certain percentage of the dollar value of the claim, keeping the remainder as his profit. The factor submits the bill to Medicaid and receives the payment from Medicaid. Thus, the provider is not paid directly, nor is he advised by Medicaid of the amount of claims submitted and paid by Medicaid in his name. Fraud and abuse through the use of factors is widespread in the State of Illinois and particularly in situations in which a doctor is merely a salaried employee of a shared health facility. Until recently, such a doctor was not aware of the amount of bills submitted in his name by his employer or factor.

The present amendments set forth in H.R. 3 prohibit a factor or billing service from being paid on a percentage basis of the claims submitted, thus eliminating one incentive to inflate bills. However, the amendment fails to prohibit payment of the claims to the factor or billing service. To avoid falsification or inflation of claims, I suggest that all monies be paid directly to the individual who certifies that he rendered medical service and then have that individual or provider make reasonable payment to the billing service for services provided. In that way, if the payments go directly to the individual who certified that he rendered the services, that individual cannot claim that he was not aware that such a bill had been submitted, nor can others utilize his name to submit false bills.

The second suggested change concerns Section 3 entitled, "Disclosure of Ownership and Financial Information." Section 3 would require disclosure, only upon request, of certain ownership information as well as information relating to business transactions by the provider. I would recommend that all of Section 3(a) be scrapped since such disclosure is by request only rather than mandatory. The practical effect of the section as it now reads would be to request disclosure only after a problem has been discovered. Accordingly, such disclosure by request would not prevent fraud and abuse, but rather would merely duplicate investigative tools already available.

Mandatory disclosure of all individuals owning a five percent or more interest in a provider would be an effective instrument by which Medicaid could determine the extent of control and involvement individuals have over entities receiving Medicaid dollars. As I mentioned earlier, our office recently concluded prosecution of seven nursing home owners who owned and operated over 20 nursing homes. These individuals generally owned ten percent or less of each of the nursing homes, but yet, by combining their partnership interests, were able to maintain operational control of those 20 or more homes. The illegal conduct of receiving kickbacks from pharmacists which these individuals practiced with respect to one home was also followed in other homes they controlled. At the present time, there is no easy method to determine the extent of an individual's or several individuals' control and involvement in providers. Our experience has shown us that what first appears to be a minimal involvement of an individual in a nursing home or medical center in fact is a substantial involvement by that individual in numerous nursing homes or clinics. Concomitantly, that individual is the recipient not of just a few thousand Medicaid dollars, but rather, as a multiple owner, receives literally hundreds of thousands of dollars in federal funds indirectly through various entities. Medicaid and Medicare should know who ultimately receives the tax dollars spent.

I strongly recommend that a provider, whether a practioner, nursing home, shared health facility, etc., be required to make the following mandatory disclosure annually as part of their certification for participation in Medicaid and Medicare:

1. The identity of all individuals who have either directly or indirectly a five percent or more ownership interest or control in the provider.
2. Expenditures by the provider to other organizations, companies, etc., in which these individuals have a five percent or more ownership interest or control.
3. The identity of all other providers in which these individuals have a five percent or more ownership interest or rontrol.
4. The annual income that each of these individuals receives directly or indirectly from each provider in which he has a five percent ownership interest or control.
5. The criminal record of any individual having a five percent or more ownership or control.

Such disclosure not only will reveal the extent of ones involvement in the Medicaid or Medicare programs, but will identify any self-dealing at the taxpayers' expense.

The third suggested change relates to the penalty provisions of Section 4. Section 4 would upgrade criminal penalties for fraudulent activities in Medicaid or Medicare to felonies, except as applied to Medicare beneficiaries or Medicaid recipients. I agree with the spirit of upgrading the penalty provisions to felonies and increasing the fine from $10,000 to $25,000. These are serious crimes, generally financially oriented, and motivated by greed. Under the proposed law, the possibility exists for the imposition of enormous fines, thus eliminating the incentive to cheat. Also, a felony conviction generally results in the automatic loss of a professional license. Such measures are a tremendous deterrent to defrauding the Medicare and Medicaid programs.

As a prosecutor, however, I also think it would be most helpful to retain misdemeanor violations providing for penalties of up to one year incarceration plus fines of $10,000. The availability of both the felony and misdemeanor provisions would allow a prosecutor to differentiate among participants in Medicare and Medicaid fraud, based upon some of the following factors: (1) dollar amount of fraud; (2) nature and extent of an individual's involvement; (3) cooperation with investigation and prosecution; and (4) mitigating or aggravating circumstances.

Finally, the language in the penalty section should be clarified to more definitively set forth the conduct which Congress intends to proscribe. More specifically, neither the present law nor the proposed amendments define the terms "kickback," "bribe," or "rebate." As mentioned earlier in my discussion of the nursing home cases, kickbacks appeared in many different forms, i.e., rent, consulting fees, professional services and other transferral payments between providers or between suppliers and providers. These different forms of payment may give a kickback an air of legitimacy even though the parties involved intend to circumvent the law.

Additionally, I suggest that the amended law clearly set forth that kickbacks, bribes, rebates, etc., be prohibited between supplier and provider as well as between providers.

The problem of fraud and abuse in the Medicaid and Medicare program is one of the most serious now facing Congress. Not only are valuable tax dollars being squandered and wasted, but Congress' ultimate goal of providing quality health care to all is not being attained. I applaud your joint efforts to rectify many of the existing problems which for too long have been neglected. Members of my staff who have had substantial experience with many of the evils present in the Medicaid and Medicare programs are available to provide these subcommittees more detailed assistance in drafting and exploring new legislation.

Due to the magnitude and far-reaching effects of the problems, we need the cooperation and action of Congress, the States, DHEW, and law enforcement agencies to provide quality health care at the lowest possible costs.

Mr. Rostenkowski. Thank you, Mr. Skinner.

You talked about kickbacks or rebates. Would you give us some examples of the ingenuity of man when you start prosecuting, what steps they will be taking to counteract any prosecution or uncovering that you are making?

Mr. Skinner. Certainly, Congressman, I will give you an example. We found in the nursing home area that druggists who had the responsibility for providing on a kickback-basis drugs to nursing homes rather than making cash payments would lease a portion of the nursing home—the nursing home operator would lease a little storeroom in his home to druggist for $2,500, $5,000, $3,000 a month. In some cases the rent for the little storeroom would be 5 to 10 times the rent for the entire building.

Yet they say, well, it's really not a kickback; it's rent for space that we have to store drugs in the nursing home. That is one example.

A commission, a finders fee for the business is another way, using intermediaries to find the business as agents on a commission basis is a third way. It's nothing more than a strawman serving as a conduit; but to the outside world, it appears to be a legitimate use of the program; and unless you get behind that, you are not going to expose that. Unless we prohibit that, they are going to continue to use that kind of device.

Mr. Rostenkowski. Is there a certain type of individual doctor, young or old, that is more subject to being taken advantage of by the factor?

Mr. Skinner. I think what we have seen in Chicago is that first of all doctors are not the best bookkeepers in the world. Lawyers aren't either, so I don't single out doctors. They aren't good bookkeepers. They dont' understand business and records. They rely on others to prepare the documents.

Number two, there are a number of doctors working in the medical mills and clinics who are foreign-licensed doctors who come from abroad who for one reason or another have not been able to establish practice elsewehere. I don't mean to demean the many fine foreign-trained doctors and foreign nationals that serve in the medical profession. There seems to be an attraction to the medical profession to foreign nationals to go into this area. They don't have the familiarity with American bookkeeping and American programs, to establish practice elsewhere. I don't mean to demean the many so I think there is a naivete on their part. More importantly, I think there is a void that exists in these areas. People recognize they are not very well controlled and administered. Th popl that would, to us the word of the street, ripoff the taxpayer in other areas, kind of gravitate to this area; and even though they have no experience in the health care field, involve themselves in providing factoring services or discount plans because no one else is there to do it.

Mr. Rostenkowski. In most instances are those foreign doctors aware of the fact that they are being used?

Mr. Skinner. I think some are and some aren't. It would be impossible to generalize; but I think they just—many of them just close their eyes and allow people to use and manipulate them.

Mr. Rostenkowski. Mr. Rogers?

Mr. Rogers. Thank you, Mr. Chairman.

Mr. Skinner, I think your testimony is most helpful. You have an impressive record in this area. It would appear that it is pretty much left to the judgment of the District Attorney, is that correct?

Mr. Skinner. I would say, Congressman, until recently if the individual prosecutor had the resources and the interest in the area, he could—I filled that void in our district because I had the interest. In other places in the country, the interest is now coming up. If a prosecutor doesn't have the interest or the concern, you are absolutely right. I can read your next question: he will not be doing anything about it.

Mr. Rogers. I think this is one problem we have had, too. I agree with you.

Now, what have you seen or how helpful is the Justice Department itself in encouraging activity in this area?

Mr. Skinner. I can speak first of all—I speak as a prosecutor of 9 years' experience having served under a number of administrations, although it appears I am under my last.

So I can speak quite frankly, although I have been prone to do that anyway. I think there is an awareness in the Department of Justice today about this problem. I served on the white collar crime committee under Deputy Attorney General Tyler, and program fraud was the No. one priority over the last year with that particular committee. We met with all agency heads, not only in HEW but HUD and others to get interest in this program, interest in program fraud efforts across the board. There is a very active division in the Criminal Division now under Mark Richard working on this problem. There are training sessions being held for prosecutors throughout the country.

Unfortunately prosecutors, unless they know about the problem, can't really identify it and do something about it. One person can make a difference. I told Secretary Califano before he spoke this morning that there was one investigator in the midwestern region for HEW for all health services programs until recently. One investigator for $22 million in programs. That one investigator, fortunately, found out about problems in the nursing home area; and on his own, he came to us with a case that resulted in nine people going to jail and well over $1 million in fines. So I think that the administration has got to put resources—has to put resources into the effort and you have to authorize it.

Mr. Rogers. May I ask you how helpful has HEW been? Do you get cooperation from the agency itself?

Mr. Skinner. I think very frankly HEW, until recently, has had their head in the sand. There are some very dedicated people within HEW who want to do something about the problem and they haven't had the support. I am delighted that Secretary Califano has demonstrated that he supports this program; and I think when he gets into it, he will find it's astronomical in nature.

Mr. Rogers. What about State medicaid agencies?

Mr. Skinner. Some are very good, some are not so good. One of the problems is the numbers you are dealing with. Congressman

Rogers, if your committee were to be expanded tenfold overnight, and you were given $22 billion worth of programs to spend and review, I suggest you would have trouble spending it properly because you couldn't manage it or administer it and it would take time to build up.

What we have done in Washington—you have done, although I don't mean to be demeaning—but we have authorized the expenditures of the programs and told a director of public aid in a particular State, you now have $2 billion to spend; spend it this year, don't give it back to us. It is going to require you to go out and hire in the next few months 4,000 or 5,000 people. They have trouble just managing the programs and getting the benefits out, let alone to investigate the fraud that occurs when they can't manage it.

Mr. ROGERS. Finally, could you let us have some of your suggestions as to definitions of kickback, bribe, or rebate, which might be helpful in writing the law and in defining those terms and the practice that you have run into since you have had to deal with the courts?

Maybe you could give us some suggestions of additional definitions?

Mr. SKINNER. We have, Congressman Rogers, been working with the staff on that. We will continue to do so. I think that the Subcommittee on Health's staff is very fortunate to have the kind of staff you do. I am sure your staff is equally prepared. We have met with Mr. Salmon and the others. I think we will be glad to work with you.

Mr. ROSTENKOWSKI. Mr. Duncan will inquire.

Mr. DUNCAN. How many indictments have you had on medicare-medicaid fraud?

Mr. SKINNER. I think——

Mr. DUNCAN. How many indictments have you had in your district?

Mr. SKINNER. I would say well over 100 individuals and corporations.

Mr. DUNCAN. How many convictions?

Mr. SKINNER. I don't think we have lost one yet. I would say there have been 50 investigations. A few are still pending. Maybe slightly less than that, Congressman.

Mr. DUNCAN. You indicate on page 9 that you have had the sale and distribution of medicaid numbers to health care providers. What has been your experience with that? Have you had indictments?

Mr. SKINNER. Not yet. That is an area under investigation. It came to our attention as an outgrowth of another one of our investigations. What we have seen and what we are currently investigating is somehow the medicaid numbers are—a list is prepared, and then it is sold to providers who then use those numbers without the knowledge of the beneficiary and send bills in to the State for payment.

Mr. DUNCAN. You just have information?

Mr. SKINNER. We do not have indictments yet. We do have evidence and testimony from individuals who say that is going on.

Mr. DUNCAN. Is it widespread?

Mr. SKINNER. I can't answer that. I suggest that if it is done in Illinois, it is done elsewhere. I don't think—I know we have some very ingenious individuals in Illinois, but I don't think we have a monopoly on it.

Mr. DUNCAN. Are the major abuses, alleged fraud violations, more prevalent in the large urban areas than in the rural areas?

Mr. SKINNER. Yes, sir, I think it is. I do not have the problems, for instance, in the western part of my district, in the Rockford area, that I do in the Chicago area. I think we have to remember that a substantial portion of resources are spent in the Chicago area and the people who need these programs are in the metropolitan areas as well. So I am not sure of the fact——

Mr. DUNCAN. What about the other judicial districts of Illinois? What about the rural districts?

Mr. SKINNER. It is to me, but I am sure it is not to a lot of others. We just haven't had that experience. I don't think we know yet, Congressman—until you go in and look, you really can't be sure. I mean these type of problems don't appear on the front page of the paper. People don't go talking about them. So I think you have to go in and look through audits, through reviews, through grand jury investigations. Then I think we are very surprised at the degree of fraud we do find.

Mr. DUNCAN. How would you suggest that the U.S. attorneys could be inspired to take more of an active interest in the prosecuting of the fraud cases?

Mr. SKINNER. Number one, you give them more resources. At the same time that we have implemented requirements for working in these areas, we have implemented the Speedy Trial Act of 1974 which requires all criminal cases to be tried in a relatively short period of time. The increase in—and I am not a great believer in a Federal presence in these areas where a State presence will suffice. I think if you want them to perform, you are going to have to allocate resources to these U.S. attorneys and make it clear that these resources are being allocated for performance or involvement in these particular areas, similar to the way that assistant U.S. attorneys were allocated and appropriated by Congress for the drug problem.

Mr. DUNCAN. Would it be desirable to fund special training programs?

Mr. SKINNER. Yes. The Department of Justice is doing that. They are very active in that area.

Mr. DUNCAN. Do you think that should be done by the State, the training programs by the State governments or the Federal Government?

Mr. SKINNER. I think it should be done jointly.

Mr. DUNCAN. Thank you, Mr. Chairman. Thank you, Mr. Skinner.

Mr. ROSTENKOWSKI. Mr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

Are there other problem areas of fraud and abuse which you feel that proposed legislation and existing authority do not address?

Mr. SKINNER. I am sorry?

Mr. CARTER. Are there other problem areas of fraud and abuse which you feel the proposed legislation and existing authority do not address?

Mr. SKINNER. I have, frankly, not given that as much thought as I probably should. I will be glad to do that and submit—I am glad to have that request. I think there are some. We have primarily been concentrating since the first of the year on H.R. 3 and our analysis of that, and our recommendations. I am delighted to have the opportunity to submit some other suggestions in other areas; and I will do so to both committees.

Mr. Carter. Yes, sir. I notice that you talk as if this was a relatively new program. Actually it was passed in 1965. This is the twelfth year of its existence; and it seems that in that time, actions should have been taken to eliminate fraud and abuse.

Mr. Skinner. I could not agree with you more.

Mr. Carter. Yes, sir.

As District Attorney, why hadn't you done so?

Mr. Skinner. I have only been U.S. Attorney for 2 years.

Mr. Carter. Yes, sir.

Mr. Skinner. In the last 2 years, I set up the first governmental fraud unit in the country. We have more indictments and convictions than any other office in the country. I think we are the model for others. I take responsibility for whatever we have done. I am not ashamed of it.

Mr. Carter. Go to the top of the class. Your modesty amazes me. Thank you, sir.

Mr. Skinner, based upon your experience in Illinois, are you able to estimate the percentage of the physician population actively involved in the fraud and abuse activities?

Mr. Skinner. No, sir, I am not. I think it is a relatively small percentage of the population that is involved; but as far as the percentage of expenditures, or percentages of medicaid expenditures that are involved, I think it is substantially higher. We have found, Congressman Carter, that a number of people—a small group of people may be responsible for a much higher percentage of the billings, 50 to 60 percent of the billings may be done by as few as 15 or 20 people.

Mr. Carter. I certainly hope so.

Thank you, Mr. Chairman.

Mr. Vanik [presiding]. Mr. Scheuer?

Mr. Scheuer. Thank you, Mr. Chairman.

Mr. Skinner, I think your testimony was extremely interesting. I have prepared a bill that I will probably submit in the form of an amendment to the bill we are considering here today that would provide wherever a State sets up a special section, a special investigative and prosecuting unit for medicaid and medicare fraud and abuse, it would provide 90-percent funding for 3 years and 75-percent funding subsequently.

They would have to be separate from other investigative and prosecuting agencies. There would have to be a maintenance of effort. It would provide the resources that you are talking about to the State officials, assuming that they wanted to really zero-in on this problem of medicaid and medicare fraud and abuse, given them the resources they need to do the job.

What would your reaction be to such an approach?

Mr. Skinner. My personal reaction, without regard to speaking for the administration—as I am sure you are aware, I do not—I think that would be very good. I think any incentives we can give to States along the area of financial resources, making it clear that they are for this particular area, would be helpful. I think that that is very important. So I think it would be a concept that is not unfamiliar to the States. We have done it under the LEAA provisions; and there are special units for organized crime being funded.

I might suggest, Congressman Scheuer, that that might be able to be done under LEAA funding. So it might be a matter of reprioritizing the problems that LEAA addresses; but I think anything we can do to financially support State agencies in dealing with this problem, we should do.

Mr. SCHEUER. Thank you very much.

Thank you, Mr. Chairman.

Mr. VANIK. Mr. Ford?

Mr. FORD. I have no comments, Mr. Chairman.

Mr. VANIK. Mr. Skubitz?

Mr. SKUBITZ. Thank you, Mr. Chairman.

Mr. Skinner, I want to commend you on your statement.

What would you estimate the Illinois bill is on every dollar expended to combat fraud and abuse?

Mr. SKINNER. I would say it could be directly as much as 5 to 1; and indirectly, as much as 10 to 1. Let me define these two terms for you. In the nursing home cases alone, this young man on my right, an investigator for HEW, a young lawyer, Glenna Freeman, who just had a baby or she would be here, put together a series of cases in the nursing home area alone, took about 9 months to prepare; three of them spent their time—almost all their—on it. We obtained a $1 million in fines in those cases; and everybody—that is direct benefit.

Indirect benefit, everybody in the industry tells us that as a result of those prosecutions, the practice no longer exists in the nursing home areas in northern Illinois. While I am not so sure that is true, at least that indicates to me that we have had an indirect benefit in return as well.

Mr. SKUBITZ. I asked the question because I have been told that it was about 13 to 1 in New York City. I wondered how it compared in your area.

Mr. SKINNER. I really—I know that Mr. Hynes, who has done an outstanding job in New York is going to be testifying. He has those statistics and figures from New York. I have no reason to doubt them. I just have been so busy trying to prosecute the cases that I haven't had time to compute the benefit; but I know it has been substantial.

Mr. SKUBITZ. Would you say the major abuses are in the hospitals or in the dental profession or doctors of osteopathy or what area?

Mr. SKINNER. I would say that it is across the board. We haven't been doing a whole lot in the area of hospitals so I am not that familiar with what is going on in hospitals, although I suggested that that is an area that should be examined. We see it in optometrists, we see it in dentists, we see it in clinicians, we see it in labs, we see it in nursing homes. I think it would be impossible to single out any one of these groups to say that is the worst.

Mr. SKUBITZ. I want to say to you that I think there may be abuses, but I think they have been grossly exaggerated as to the amount of abuse. I looked at some of the figures in my own State. When I find them in that area there, medical doctors—I can't see much wrong. I find a few, just a few of them. When you take a case, point out someone making $150,000 and leaving a cloud on all the other doctors, I don't think that is a fair thing to do. I thought that's what the Secretary did this morning when he took one case and then leaves the impression that the whole medical profession is doing that sort of thing.

Mr. SKINNER. That question came up when I testified before in the Senate Committee on Aging. I think you are correct, that a substantial majority of the members of the medical profession are performing in the highest tradition of their profession. It is a very noble profession. Unfortunately for some reason, a number of them have gone astray; and a number of people who have no concern for health care have involved themselves in this area, and they are bringing the entire profession into disrepute. We have made it awfully easy for them by allocating these programs without control, without any type of gradual implementation; and I think we have to take responsibility. But I thought the Secretary later clarified that; and I am sure he meant to if he didn't, the fact that all doctors aren't involved and many of them are performing very admirably. There are too many, just as there are too many lawyers, that are going wrong; and we have to address that problem.

Mr. SKUBITZ. I suggest to the members of the committee before they talk too loudly or too long, they better go into their own States and get the amount of money paid out and then make a determination about what direction we ought to be going.

Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Mrs. Keys will inquire.

Mrs. KEYS. Thank you, Mr. Chairman.

Mr. Skinner, would it be a significant aid to your office and others like yourself if there were a uniform system of accounting and statistics' keeping and required reporting by all the health care providers?

Mr. SKINNER. I am not as enthusiastic about that type of program as I am about other steps that I think could be taken. It appears to me that that would be of some assistance to the auditors because they wouldn't have to learn the system again and again. It appears to me that right now under medicaid, we have 50 different programs, and each is a little different. We don't have any standardization as we do under medicare. I think one of the areas that we should give some thought to is the standardization of requirements in the medicare area across the country so we have a standardization so we treat these programs and the beneficiaries and the providers on an equal basis rather than relying on 50 different States to come up with their own individual approach without a whole lot of coordination with others.

So I don't want to—I just don't think that will be as helpful as some of the other things I have suggested. I am not against it.

Mrs. KEYS. We are attempting in this bill to do something to aid in the detection and actions regarding fraud and abuse. Do you think it is really going to help us in terms of auditing to require the providers to open up their books to Federal as well as State people if we don't have a uniform accounting and statistical keeping system?

Mr. SKINNER. I think you have to make it as easy as possible for the auditors and investigators who are going to have to review these organizations and their expenditures and their revenue. I think a standard accounting system throughout the country would be helpful along these lines; and to that degree, I think yes. So it certainly—anything we can do to make the job easier, I think, is a good step forward.

If I might just finish, Congresswoman Keys, it is very difficult to investigate these type of cases. Make no mistake, it is not like investigating a bank robbery where you have three eye-witnsses or a tape that surveilled the entire offense. You have to go—in the case of dentist, we have to have another dentist look at the dental work and decide whether or not the work that the State was billed for was done. That is very difficult. We have to talk about need; and it is a very subjective judgment. So these cases are not easy to investigate; and the simpler we can make the procedures, the easier it is going to be to uncover fraud.

Mrs. KEYS. You pointed out the success and what happens when there is one good investigator; but probably we never can get enough investigative personnel in the field to go in and review every one. We best try to do as much as we can to enable us to detect it in some kind of a review by Federal or State reviewing groups.

Mr. SKINNER. I agree with you. We don't have enough prosecutors. That is too late in many cases. I did go back to my point: Before we start implementing these programs, we should do it on a gradual basis, it appears to me, and do a test-marketing as you might do with a new product so you can see how this is going to work, and you can tune-up the system so to speak before you actually begin implementation on a $10 billion—$20 billion basis. That is what they do in almost any other area; and we don't do that in this area.

Mrs. KEYS. Thank you, Mr. Skinner.

Mr. ROSTENKOWSKI. Mr. Pike will inquire.

Mr. PIKE. Thank you, Mr. Chairman.

I appreciated your testimony very much, Mr. Skinner, with perhaps one exception. Having previously announced that I had for most of my life been in the health case businness and having previously had to restate this many, many times, and have always been rather proud of it, would you mind in your statement about disclosure saying instead of the criminal records of the owners of a corporation, saying the criminal records, if any, of the owners of the corporation? [Laughter.]

It does seem to me that your statement sort of tends to indicate that all providers of medical services are criminals; and I find that just a little bit difficult to live with.

Mr. SKINNER. I would seek, Congressman Rostenkowski, to amend my statement.

Mr. PIKE. I am interested in one other thing that you said, Mr. Skinner, early on—and it is not a part of your written testimony—that there are pending grand jury reform measures and tax reform measures which will make it more difficult for you to perform. What measures are you talking about?

Mr. SKINNER. As you are probably aware——

Mr. PIKE. I might not be.

Mr. Skinner [continuing]. There were a number of bills introduced in the last session of Congress which would limit substantially the length of grand jury service, the sentences for reluctant witnesses; they would require additional showings before——

Mr. Pike. What are the present sentences for reluctant witnesses?

Mr. Skinner. The present sentences, if someone refuses to testify, it goes to 18 months. They can be incarcerate up to 18 months. There are some efforts to decrease that to as low as 6 months. In other cases, even more, there are steps, for instance, that would allow a witness who has been subpenaed in another district, allow him to contest that subpena in the foreign district before he would have to provide the records.

Now, this would mean that in that particular case, the investigation could be delayed for weeks and people would by flying all over the country and exposing the investigation itself in order to meet some requirements in a foreign district on a subpena; and I just don't think the abuses that have occurred throughout the country—and there have been some as in any area—do not warrant that type of strong legislation.

Mr. Pike. These particular provisions would be outside of the jurisdiction of any committee I serve on.

You referred to tax reforms. Would you tell me what tax reforms? This would be within the Ways and Means Committee's jurisdiction.

Mr. Skinner. There is not a prosecutor or a U.S. attorney in the country, Congressman, who is not concerned about certain aspects of the Tax Reform Act of 1976, as far as what can happen to that individual if tax return information, through no fault of his own, is disclosed to others or it's left on a table. There is very strong restrictions on who this information could be disclosed to, even though the people may work for the Federal Government and be working on the case.

Mr. Pike. Do you feel that there should not be strong restrictions on what—on who tax return information should be disclosed to?

Mr. Skinner. No, sir, but I think they should be—at least the people who are working on an investigation, whether they be staff members or U.S. attorneys, should have access to that information. I don't think you will find many cases of abuse by U.S. attorneys on tax information in the last several years anywhere in the country. I have been in this business 9 years as an assistant, first as an assistant, and now U.S. attorney. I know a host of U.S. attorneys throughout the country. I think there have been abuses on tax information at the White House and elsewhere; but you have now penalized the prosecutors.

Mr. Pike. Nobody has penalized anybody yet. I am trying to figure out what you are talking about here as to what your concern is.

Mr. Skinner. I will give you an example, Congressman Pike. Let's assume for a minute I am working at my desk on an important nursing home investigation. I have received, after a great deal of paperwork being prepared and court orders, a tax return from a nursing home operator. I leave my office door open as I go to the washroom down the hall and some individual who is in our office as a witness or an employee of another agency comes through my office or walks into my office while I am in the restroom, takes the return information, or copies it down and leaves within a two-minute span.

As many of us interpret the new legislation that passed, I will lose my job because of that. I have lost it already, I think; but there are many career people who I don't think are going to lose theirs. I certainly will have to defend myself in a lawsuit on maybe a civil and possibly a criminal basis. All I did was go to the washroom and leave information on my desk.

Now, maybe our concerns are not well-founded, but almost all of us feel that way.

Mr. PIKE. Well, I think your concerns may possibly be well-founded. Obviously we are weighing one good principle against another good principle.

Mr. SKINNER. Yes, sir.

Mr. PIKE. We are weighing your right to prosecute cases, or your ability to prosecute cases effectively, or even to go to the washroom, against the right of the taxpayers to not have their tax returns made public; and I think—I am not sure I am wholly in sympathy with you on that issue.

Mr. SKINNER. Congressman, remember I said you should consider this and my statement and weigh it. I am aware it is a weighing process. I am making you aware of a problem which every—and many of these people are professionals in the highest sense. I have two young assistants on my staff, if they were to lose their law license to practice law because of a conviction, and I wasn't making their concerns known, I wouldn't be a very good manager.

Mr. PIKE. That is all, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Scheuer?

Mr. SCHEUER. No further questions.

Mr. ROSTENKOWSKI. Mr. Walgren.

Mr. WALGREN. No questions.

Mr. ROSTENKOWSKI. One more question, Mr. Skinner.

I take it that you are not impressed with the authority that we give the Secretary with respect to disclosure, ownership of financial information. We suggest that the Secretary, upon request, will ascertain disclosure or ascertain ownership. Do you feel a little differently toward it?

Mr. SKINNER. Yes. We have suggested mandatory disclosure. We don't think it has to be disclosure that is—you know, that is known throughout the country. There could be privacy attached to it through regulations; but at least people that are responsible for regulating these programs should have readily available to them this information before they—so if they have a problem they can immediately identify the problem rather than getting a formal request together, going to the individual provider, even litigating the request, and 2 or 3 months ensuing before they get the information. We feel that under a privacy protection, this information should be part of a requirement for any recognition by the Federal and State governments in these areas.

I don't think that that is an unnecessary burden; and I recognize that a lot of people have problems with it. We are in different times. There is disclosure everywhere. I think this is one area where there ought to be more disclosure than there is.

Mr. ROSTENKOWSKI. Mr. Pike?

Mr. PIKE. No questions.

Mr. ROSTENKOWSKI. Mr. Brodhead?

Mr. BRODHEAD. No questions.

Mr. ROSTENKOWSKI. Thank you, Mr. Skinner.

Mr. ROGERS. Mr. Chairman, I wonder if your assistants have anything they think the committee should be aware of or that you you would like to have them speak to?

Mr. SKINNER. Mr. Elsbury?

Mr. ELSBURY. I might refer to one matter, Congessman Rostenkowski, brought up earlier about the types of doctors or situations in which various frauds are more prevalent. It ties very much to our recommendation with regard to a key factor. That is whenever doctors, optometrists, dentists, et cetera, are working on a salaried basis such as $10 an hour, $25 an hour, for a shared health facility or medical center, instead of working on their own, the possibility of fraud is much more likely; and this is where we run into the factoring situation, where someone else is submitting the bill for the services rendered by that particular doctor who is working on an hourly basis. These are the doctors which Mr. Skinner mentioned that later come in and say, "How could there be $150,000 worth of bills issued in my name? I worked 8 hours a day, 2 days a week."

The additional problem that those types of situations run into is that in these medical centers, a different doctor will be working each day, Monday, Tuesday, Wednesday, Thursday, and Friday. When you are trying to find the recipients or alleged recipients of medical care, it is going to be very difficult for them to recall what doctor, if any, did treat them because it is not the family doctor situation. Every time they go to the medical center, there is a different doctor.

Mr. ROSTENKOWSKI. Would the gentleman yield?

Mr. ROGERS. Yes.

Mr. ROSTENKOWSKI. What about explanation of benefit forms for the poor? Have you found that effective, where there is an explanation of benefits sent to the poor so that they realize what health——

Mr. ELSBURY. What services they have received?

Mr. ROSTENKOWSKI. Yes.

Mr. ELSBURY. Let me say this: Medicare, as a part of the medicare program, whenever the financial intermediary issues a $200 payment to the doctor or the health service on behalf of the payment, a letter also goes to that payment telling him we have just spent or given $200 to doctor X, for house calls or for an operation. In the medicaid—in Illinois, this process is not followed; and a number of medicare cases have resulted just because of the fact that a patient got a notice from medicare saying—mentioning payments to a doctor when they know those services were not rendered. I think if the same statements were sent to public aid recipients, they might also react.

For example, our family did not receive $250 worth of glasses during the last month; and they would say that doctor is ripping us all off. I think they would take time—or at least some of them would take time to bring that matter to the attention of the proper authorities.

Mr. SKINNER. In other words, yes.

Maybe Ms. Tighe would like to speak to that?

Ms. TIGHE. I think I made a note on precisely the question Mr. Elsbury addressed. I think he adequately covered it.

Mr. ROSTENKOWSKI. If there are no further questions, we thank you very much, all three of you, for helping us with your testimony.

Mr. SKINNER. Any time our office can be of help to either committee, we are more than willing.

Mr. ROSTENKOWSKI. Thank you, Mr. Skinner.

Mr. Hynes?

STATEMENT OF CHARLES J. HYNES, DEPUTY ATTORNEY GENERAL, SPECIAL STATE PROSECUTOR FOR NURSING HOMES, HEALTH AND SOCIAL SERVICES, STATE OF NEW YORK, ACCOMPANIED BY HARRY F. BLAIR, ADMINISTRATIVE ASSISTANT; AND ALBERT F. APPLETON, EXECUTIVE ASSISTANT

Mr. HYNES. Thank you, Mr. Chairman.

On my left is Harry Blair, who is the administrative assistant for our office. On my right is Albert Appleton, who is the executive assistant.

I would like to point out that Mr. Califano and I are in agreement. I do not like special prosecutors either. I am a deputy attorney general. I would also like to say for the record that we are proud to have Congressman Pike in New York State. He is probably one of the better health providers we have.

[Congressman Pike applauding.]

[Laughter.]

Mr. ROSTENKOWSKI. Let the record show one individual applauded.

Mr. HYNES. Let me begin by telling you how much I appreciate the opportunity to appear before you today.

Twenty-six months ago, one of your former colleagues, Hugh L. Carey was sworn into office as Governor of the State of New York in the midst of a nursing home scandal, one which fundamentally challenged the ability of government in New York State to fully respond. As early as September of 1974, we in New York were subjected to a barrage of newspaper headlines and television exposure detailing the squalid, inhuman conditions inside nursing homes in every area of our State. What was equally appalling was the allegation that a significant portion of New York's billion dollar budget for nursing homes was being diverted into the pockets of unscrupulous providers.

State government simply had no available mechanism to prove or disprove what seemed then to be incredible allegations of wholesale medicaid fraud perpetrated under the guise of providing patient-related care.

On the 10th day of his new administration, Governor Carey established my office and directed me to commence a statewide investigation and prosecution of those who committed crime in connection with the establishment, operation or regulation of some 700 nursing homes in New York. In addition the Governor convened an investigative commission known as the "Moreland Act Commission" and charged it with the responsibility of providing legislative solutions to problem conditions in the nursing home industry.

Mr. Chairman, I am proud to say that despite enormous fiscal problems, the Governor and the New York State Legislature have made a major commitment to this investigation by insisting from the outset that the resources made available to me mirror the broad scope of the potential problem. As a result, we are now the largest single office in the country dedicated to the investigation of white-collar crime—we have a staff of more than 400, including some 300 professionals—working together out of seven regional offices located in key areas throughout New York State.

If I may, I will address myself now to the investigative areas we have developed and which have relevance to the bill before you. My first concern was the potential for human misery, which prompted us to open an inquiry into patient abuse.

You must remember that in 1975, we were entering an investigation involving some 700 nursing facilities—from tiny operations housing 20 to 30 patients to giants of 400 to 500 beds—in all accommodating more than 60,000 citizens often both very old and very sick.

Beginning in March of 1975, and with the cooperation of the New York State Department of Health, we initiated a continuing series of unannounced onsite inspections of nursing homes throughout the State. With the full understanding that neglect in and of itself may not be punishable under the penal laws, it is our firm conviction that the quality of care can be improved—if not through prosecution then, at least, by the threat of prosecution and the certainty of inspection.

I should point out, Mr. Chairman, that this procedure is followed with scrupulous regard to the rights of the nursing home owners. The results of this program so far have been encouraging for with each new wave of inspections we have observed that care has begun to replace indifference and the number of complaints regarding patient care has fallen to a trickle.

The other major area of concern was a widespread and pervasive pattern of medicaid fraud. What 2 years of our investigation have established is that medicaid has failed—not in its ideals but in its execution.

Our country's worthy effort to guarantee that its poor and its elderly get the kind of basic health care that is the right of every human being has been plagued with bloated cost, mismanagement, and a total lack of enforcement.

In New York State, during the period from 1970 to January of 1975, there was not a single prosecution for medicaid fraud arising out of the operation of a nursing home.

During the same period, the New York State Department of Health had no more than 16 auditors to review the books and records of more than 2,400 nursing homes, health-related facilities, shared health facilities—medicaid mills—and hospitals.

In those rare instances when a health care provider was found to be defrauding the State, the most severe punishment handed him was a negotiated repayment of a portion of theft.

As of today, grand juries in New York have indicted more than 90 individuals, mostly for medicaid fraud. What seemed to be incredible charges of fraud in late 1974 and early 1975 has since become a disturbing reality.

We have concluded that the false submission of direct costs is but one aspect of provider fraud. We have uncovered phony construction costs and concealed ownership of related companies in webs so entangled that even cooperating potential defendants cannot set them straight.

In November of 1976, grand juries in five New York counties, empaneled by my office returned indictments against 26 nursing home owners, operators, employees, and suppliers alleging a scheme involving kickbacks which ranged between 5 percent and 33 percent of the volume of business from suppliers of various goods and services to health care facilities.

But the all-time favorite approach to medicaid fraud was for health care providers to write off personal expenditures as patient-related costs and to receive in return taxpayers' dollars. The following is a laundry list of some of these items, which is drawn from a series of our completed prosecutions: Personal maids and servants; private residential landscaping; travel expenses; food items at levels you would not believe; luggage; works of art, including paintings by Matisse and Renoir; vast quantities of liquor; interior decorating; dental and medical care; pharmaceuticals; heating fuel for private residences; charitable contributions; political contribtuions; profits to investors; private automobile expenses; private pension plans; vacation expenses; real estate taxes; mink coats; personal investment stock; renovations to private homes; entertainment; legal fees; theater tickets; tickets for sporting events; high fidelity stereo equipment; and secret personal profit.

In other words, we have found ourselves steeped in the investigation of a massive, institutionalized and ongoing white collar criminal conspiracy.

The prosecution of these cases has been subjected to interminable delay, occasioned by protracted pre- and post-indictment litigation. While we have successfully litigated subpenas for the books and records of various nursing homes in 126 out of the 128 cases, the median time required to bring about court resolution to motions to quash a subpena was 135 days.

In one case, 636 days after the issuance of the subpena and after extensive litigation, including up to the U.S. Supreme Court, the nursing home operator has not yet produced the books and records properly sought by the grand jury.

Despite these delays, there have been 27 convictions, the majority of which were for medicaid fraud, and we have forced payment or assignment to our office of more than $4 million, in criminal restitution, an amount, Mr. Chairman, which is several hundered thousand dollars above our first years' budget.

In addition to our criminal investigative function, my office has a civil audit and fact-finding responsibility. In 1976, with the budgetary support of the Governor and the New York State Legislature, we increased our audit staff and commenced an in-depth audit of the entire proprietary nursing home industry.

Based on our 1975 work, we projected that we could, with additional investigative staff, identify for recovery by the State a minimum of $70 million in fraud and abuse. Today, with completed audits of slightly more than 50 percent of the proprietary nursing homes, we have uncovered fraudulent overpayments of more than $45 million. By the middle of March, we will have turned over to the New York State Health Department audit reports designed to begin the process of recovery of nearly $20 million.

During the last 2 years, Mr. Chairman, we have shared our information and expertise with more than a dozen States. We have had liaison particularly with representatives from Massachusetts, Ohio, New Jersey, Colorado, and Wisconsin.

In November of 1976, I had the privilege of participating at a fraud and abuse control seminar sponsored by the Department of Health, Education, and Welfare in Dallas, Tex., where I had the opportunity of speaking with representatives of many other States. If that experience taught me anything, it is that New York State has no monopoly over the problems of medicaid fraud and abuse.

The difference is that New York, at tremendous financial sacrifice, made a profound commitment to reverse the tide of theft and abuse. What we have also learned is that New York's effort has reached a level where it is not only paying for itself, but, that it now has the potential for making money which can be used for other State purposes.

There is every reason to believe that other properly funded State investigations can reap a similar benefit.

But, the other State investigations have informed us that they are unable to obtain the necessary startup funding for such a project from their governments.

Currently, Mr. Chairman, we have a situation that does not really make sense. The Federal Government each year gives out literally billions of dollars in taxpayers' money to fuel the engines of medicaid and medicare. This is done within a framework of laws, rules, and regulations which, for the most part, are reasonable and workable. But from an enforcement point of view, Mr. Chairman, there is very little now being done either by the Federal or State Government in proportion to the magnitude of the problem.

At this point, Mr. Chairman, I want to make it clear that my purpose here is not to blame anyone for this state of affairs or charge negligence or anything else.

The reasons for this state of affairs are many and varied, and I am confident that it is not through willful neglect that we find ourselves in our current predicament.

Nevertheless, we are where we are and the situation, from the law enforcement point of view, is desperate. Still, rather than weeping and wailing, I would treat it as an opportunity to start from scratch and fashion an effective nationwide enforcement structure that can turn the currently crowded profession of stealing Federal and State health care moneys from one that is respectable and risk-free to a perilous and despicable pursuit.

By way of analogy, Mr. Chairman, I would point to the Internal Revenue Service which by dedication to a high standard of professionalism and great vigilance has made the evasion of income taxes in this country into a most hazardous occupation.

It seems to me that with the growing amounts of moneys being expended in pursuit of health care schemes in this country each year we can do no less.

Established State prosecutors, such as district attorneys, are currently so overworked, understaffed, and underfinanced that it would be wildly unrealistic to expect that they can cope with health care fraud.

As I have explained, the schemes in operation are so complex, wide ranging, and sophisticated that they require a special staff of highly trained professionals working fulltime to even provide the ghost of a chance of coping with them.

The U.S. attorneys currently are in much the same position. Most, if not all of them, are currently stretched to the limit of their resources to deal with ongoing criminal and civil problems and lack the resources to take on pervasive and complex fraud schemes, such as those extant in the health care field.

If one considers the nature of health care fraud as I have discussed here today, I think it is fair to say that this reflects no discredit on these agencies. Clearly, to combat health care fraud on an ongoing and effective basis, a special and separate investigative and prosecutorial framework is necessary; and I see no alterantive but that it be Federal.

This is not to say that I do not believe the States have a role to play, and an important one. I think the Federal Government could develop a framework, perhaps along the lines of one that I will suggest to you in a moment, and then integrate those States into it that are willing and able.

The Federal authorities should create a set of standards against which to measure a State's application to participate. As the prime example, it is clear to me that effective fraud control is impossible without the power to prosecute.

It was the power to prosecute that enabled us to uncover vendor-operator conspiracies. It was the power to prosecute that confirmed the success of our audit activity. Most importantly, the realistic certainty of criminal sanction is absolutely essential to deter theft.

The State agency of which I speak must be located in whatever State governmental unit the jurisdictional authority to prosecute exists: a free-standing self-contained unit with a combined audit, investigtive, and prosecutive function.

Such a unit should not be mixed in with audit and investigative units already located within a program agency with the hope that local prosecutors will pick up the last step.

Programs and prosecution simply do not mix.

Enforcement would become buried and lost in a program agency, except in times of scandal or public outcry. Day-to-day dealings with industry participants would always raise questions of the program agency's conflicts of interest, and of its ability to conduct disinterested enforcement activity. This is particularly true where realistic criminal sanctions are in the offing.

In those few States which have no statewide prosecutorial jurisdiction whatsoever, the audit and investigative units ought to be located within the office of the State attorney general which would have the responsibility of monitoring the referrals to local prosecutors.

To sum up, then, Chairman Rostenkowski and Chairman Rogers, and other members of the committee, a participating State should have an agency that is:

Independent and has as its sole function elimination of medicaid fraud;

It should have statewide dimension to properly coordinate multicounty investigations;

It should have an integrated staff of auditors, lawyers, and investigators with the ability to handle all aspects of the investigations and;

It should be required to issue an annual report, not only reporting activity but making recommendations for better control of fraud and administration of medicaid on the basis of its findings.

Once meeting these standards, a State would be eligible to receive the kind of funding which is the subject of one of the amendments before your committee, I should point out, Mr. Chairman, that I testified last November before the U.S. Senate's Special Committee on the Aging and recommended among other items that there be an initial funding by the Federal Government of 100 percent for a 3-year period dropping down to a formula of 50 percent matching grants thereafter.

I did this because some of the States' representatives expressed the concern that their fiscal problems would preclude any matching funds.

But whether the initial Federal share is 100 percent or 90 percent, the need exists to provide a powerful incentive to the States to establish an ongoing and effective agency to police the expenditure of health care dollars. It will, in the long run, lessen the Federal burden by the establishments of Federal-State partnerships.

In addition to this program, I strongly recommend additional Federal intervention to keep the health care entrepreneurs honest and prevent a recurrence of the present chaotic situation.

To do this, I would suggest the establishment of a special bureau or office within the U.S. Department of Justice dedicated entirely to health care fraud.

This bureau would have to be staffed with the same types of professionals—auditors, investigators, and attorneys, all schooled in the mysteries of the delivery of health care services, that we have developed in New York State, operating under the same strike-force type of philosophy without which indictments and convictions in this field would, in my opinion, be next to impossible to obtain.

In addition, I would suggest that each of the 90 U.S. attorneys be provided with an assistant, in addition to the complement he is now allowed, who would work full-time in the health care fraud area with the cooperation of the bureau I mentioned operating out of Washington, D.C.

The personnel of this Washington bureau could be loaned on an as-needed basis to the various U.S. attorneys. In those States with agencies of their own that received Federal certification, the State agencies and the U.S. attorneys could work in tandem both with each other and with the Washington bureau.

In my view, this, or something like it, is clearly what is needed. Many of the targets of our investigations operate across State lines, and, of course, as a State prosecutor, I am unable to follow them once they leave New York.

In addition, I have found that the trail of fraud and thievery leads to medicaid mills and hospitals.

Mr. Chairman, the conspiracies to defraud the public in the health care field are enormous in scope and complexity. To cope with them effectively will require a massive effort on the part of the Federal Government. I see no other way.

Mr. Chairman, in conclusion, I would like to quote something to you:

> Beyond the specific instances of fraud and deceit as they may be revealed and must be dealt with, we are bending every effort to produce constructive results that will prevent recurrence of cheating and misrepresentation; results that will strengthen administration of regulatory and medical care programs of city departments and above all results that will upgrade proprietary nursing homes in respect to operational effectiveness and quality of patient care—all in the public interest.

Mr. Chairman, these words were spoken some 17 years ago by Louis J. Kaplan, then New York City investigations commissioner and author of the celebrated Kaplan report.

Those residents of the homes now dead who were the shills of avaricious health care entrepreneurs have been replaced by a new generation of our elderly who in 1960, hear, but did not listen and were thus condemned to live the repeated history of a scandal which is no longer a vague newspaper headline but is instead reality itself.

Well, this time it has to be different. This time we do have to clean it up permanently. And if we cannot prevent it from happening again, we must prevent it, at the very least from becoming respectable and risk-free to deal with old people like a commodity in the futures market in Chicago.

Those who care about the poor and the elderly are now swallowing the bitter pill of cutting worthy programs to make up for losses to fraud and mismanagement; those who desperately need some form of national health insurance must realize that until we contain the misuse of medicaid funds, any other health program would be put another step toward bankruptcy and so they are left to their prayers for good health, while concluding that only the corrupt and inefficient seem to be the most visible beneficiaries of medicaid.

It is their visible prosperity that sticks in the throat of the working taxpayer. But we can change this.

Mr. Chairman, the interest and dedication of this committee can begin the long-term overhaul of the medicaid system and return medicaid to the service of the poor and the elderly.

Thank you.

Mr. Rostenkowski. Thank you, Mr. Hynes.

Mr. Rogers?

Mr. Rogers. Thank you, Mr. Chairman. That was a very helpful statement, Mr. Hynes. The work you have done certainly should set an example for others to try to follow. What is your cost for the size of the operation?

Mr. Hynes. Our current cost is $7 million.

Mr. Rogers. It started out at what?

Mr. Hynes. Three. About $3.5.

Mr. Rogers. How many people do you have?

Mr. Hynes. Approximately 415. That includes about 70 lawyers, statewide; about 156 auditors, and about 100 investigators. The rest is backup staff.

Mr. Rogers. Would it be helpful if there were provisions for uniform accounting, not uniform reporting, but uniform accounting in nursing homes?

Mr. Hynes. I think it would be extremely helpful in terms of our investigation and in terms of inspection controls within the Department of Health. I do not think anyone would suggest that it is a panacea. I think investigation is also very, very important to enforcement. I think it is a tremendous aid.

Mr. Rogers. Is there much recidivism in this field?

Mr. Hynes. I can only tell you this. Seventeen years ago, Eugene Hollander, one of our major nursing home operators, was discovered defrauding the State by Louis Kaplan. The charge at that time, I think, was that he has stolen more than $125,000. He was forced to pay back $30,000. He was indicted by us last year.

He was convicted on his plea of guilty. He was fined $1,000,250. He has paid to date about $800,000 of that money.

Mr. Rogers. Thank you very much.

Mr. Rostenkowski. Mr. Hynes, do you have any problems with your investigations and your prosecutions with the Federal Government in exchanging information.

Mr. Hynes. No; we have had a very fine working relationship, not only with the local regional office of HEW, but with three of the four U.S. attorneys in New York State.

As for the other one we have not worked with him yet. I am sure we would have the same kind of cooperation.

As a matter of fact, as a result of the cooperation we have received, we sent a letter of strong support to Senator Moynihan for his proposal to retain those U.S. attorneys. We are very, very happy to see they were retained.

Mr. Rostenkowski. What about information, statistical information? Do you have any problems with that?

Mr. Hynes. None, none whatsoever.

Mr. Rostenkowski. Mr. Hynes, it concerns me how these abuses—these fraudulent practices can mushroom. It seems the ingenuity of man moves in the wrong direction faster than it does in the right. Could you give us your thoughts on that?

Mr. Hynes. There is very little doubt on that, Mr. Chairman.

Of course, you know the reason the problem became so critical in New York State had very much to do with the lack of enforcement. Sixteen auditors to control 2,400 facilities just does not make any sense, in addition to which, as I pointed out, when someone was apprehended in those rare instances, they never paid dollar for dollar return.

They would pay a portion of it. In addition, they were able to hire some of the better law firms in the State and some of the better accounting firms in the State; and then I think the word is chutzpah, they had the chutzpah to then seek reimbursement of these costs from the State of New York. They actually did receive reimbursement for legal fees and accounting fees claiming it was related to patient care. They had to defend the home.

Mr. ROSTENKOWSKI. It is amazing how "ripping-off" the Government becomes so contageous?

Mr. HYNES. It surely is.

Mr. ROSTENKOWSKI. Mr. Duncan?

Mr. DUNCAN. Thank you, Mr. Chairman.

I want to thank you, Mr. Hynes, for your excellent presentation and the useful information that you have given us. Do you believe that the States generally speaking are capable of effectively preventing and prosecuting medicaid fraud; and if you think so, what do you think the role of the Federal Government should be?

Mr. HYNES. I think they are effective. We have worked particularly close with the Massachusetts attorney general, Francis Bellotti. He has investigated medicaid fraud with just no resources. I think he has allocated 12 members of his staff to some of the investigations; but—he reflects the complaints I have heard from all over the country, that the States simply do not have the resources to handle this kind of investigation.

We were fortunate in New York, I suppose in one sense, that we had a scandal. I do not think we would have had the kind of enforcement we have had in New York State without the scandal. There is very little doubt in my mind that if the Federal Government, on the one hand, is spending enormous sums of money on medicaid-medicare programs, can give just a portion of that—and that is all we are talking about, a portion—to setting up funding for State agencies for enforcement, that we can make a difference.

We can turn this thing around—I think we have turned it around significantly in New York State. There is no reason to believe why other States who may have a similar problem cannot do the same thing.

Mr. DUNCAN. How many convictions have you had?

Mr. HYNES. Twenty-seven convictions, one acquittal, three dismissals. Of the three dismissals, one was affirmed by the court of appeals. The second dismissal is being appealed; and the third one was reversed by the appellate division and the defendant pleaded guilty.

Mr. DUNCAN. What was the penalty on the average?

Mr. HYNES. It has been—it has ranged from what I can only characterize as a slap on the wrist to some significant penalties. A nursing home operator in Buffalo who was convicted after trial of extortion received a 10-year jail sentence. Most recently, a nursing home operator in Westchester who was convicted after trial of stealing some $75,000 received a three-year jail penalty.

We have had some problems initially with judicial attitudes, the same kind of judicial attitudes we have had with white-collar criminal cases in general, a reluctance to send people convicted of white-collar crimes to jail.

I think we are starting to—we have turned the corner in New York State.

Mr. Duncan. Someone yesterday—I do not recall who it was—suggested that perhaps the Federal Government or the State government should operate the nursing homes and not private enterprise. What would your feelings be on that?

Mr. Hynes. I hope that never happens, Mr. Duncan.

Mr. Duncan. I do also.

Mr. Hynes. Unfortunately—and it is something that Mr. Pike pointed out and Mr. Carter, I believe, before—what is unfortunate about these investigations is that we talk so much about the abuse, and the horros of the abuse. We give very little time to those proprietary owners in the State who are doing an excellent job and working within the system.

We have a significant number, a substantial number of proprietary owners in the State of New York who have tried to work within the system and run an honest business.

Mr. Duncan. What percentage would you think of your proprietary homes are operating ethically within the law?

Mr. Hynes. It is more than half. That is a substantial number as far as I am concerned.

Mr. Duncan. Do you think the State agencies that set standards for licensing, certification, accreditation of health care providers and facilities are in a position to help control medicare-medicaid fraud?

Mr. Hynes. Your question is can the regulatory agency do it?

Mr. Duncan. Yes, sir.

Mr. Hynes. Not in my judgment. They simply—I do not believe the program and prosecution mixes. Prosecution is key to control. They can set up regulations. With their inspection role, they can keep a check on the problem in that sense. I just don't believe they can do the effective job that is possible through prosecution.

Mr. Duncan. You think the Federal Government should accredit—take complete control of licensing and accreditation?

Mr. Hynes. Not at all. I think it can be a partnership arrangement.

Mr. Duncan. Thank you very much.

Mr. Rostenkowski. Dr. Carter will inquire.

Mr. Carter. Thank you, Mr. Chairman.

Much of your work has been directed to the detection of fraud. We realize, though, that abuse is a more elusive concept which is more a matter of the degree of violation. What has been your experience with detection of abuse?

Mr. Hynes. It is very difficult, Dr. Carter. I pointed out neglect in and of itself is not prosecutable. What we have had is several convictions for patient abuse. In one instance a patient was beaten. In another instance, a nursing home operator in Westchester County was prosecuted for running what can only be described as a sewer. It was in desperate shape; exits were blocked, excrement on the floor. The smell of human feces, a terrible situation. He was convicted of 12 counts of violating the public health law. We have had very little of that because the laws are not there to control neglect. It is very difficult to assign culpability. What has happened with the inspection that is run jointly by my office and the Department of Health, we found an enormous clean up; and some indication that care has changed enormously.

Our care problem is basically confined to urban areas: The upstate areas, the suburban areas were pretty good. There has been significant changes as far as we are concerned.

Mr. Carter. One of the abuses I was considering was overuse, for instance, or over-ordering of lab tests, X-rays and things such as this.

Mr. Hynes. Dr. Carter, I am limited in New York State to the investigation of nursing homes, both proprietary and voluntary homes, also health related facilities (HRF's), what you call ICF's, and adult homes, which you might know as DCF's. I have no jurisdiction over hospitals or the medical profession.

Mr. Carter. Thank you very kindly.

Mr. Rostenkowski. Mr. Pike will inquire.

Mr. Pike. Thank you, Mr. Chairman.

Mr. Hynes, you have made the analogy between your operations and the IRS; and I can only say that being on the other side of the street sometimes your visits are usually treated with the same joy any individual has on being told that his tax return is about to be audited.

Mr. Hynes. I am sorry to hear that.

Mr. Pike. Well, it is a human failure, I guess.

I first want to commend you for the priorities which are revealed both in your statement and in your operation in that you looked first at the manner in which human beings were being treated, the pain and suffering involved with human beings. I am glad you put that first; and I hope that our State will continue to put that first.

I would like to continue to try to put in perspective the degree of problem that we have here. At the bottom of page 13, top of page 14, you say that you have now completed audits of slightly more than 50 percent of the proprietary nursing homes. You have uncovered fraudulent overpayments of more than $45 million.

How many nonfraudulent overpayments have you found?

Mr. Hynes. We have found significant problems in what for lack of a better phrase would be civil fraud, where—items for patient-related expenses, where they should have been disallowed.

Mr. Pike. Can you give me a degree, a ball park figure in millions of dollars?

Mr. Hynes. $45 million.

Mr. Pike. No. I am talking about nonfraudulent.

Mr. Hynes. About 50 percent.

Mr. Pike. About 50 percent of this figure?

Mr. Hynes. Yes.

Mr. Pike. That would be another $22.5 million?

Mr. Hynes. Is noncriminal fraud what we are talking about?

Mr. Pike. That is right. What I am trying to get at is the pervasiveness of overpayment in addition to fraud or criminal fraud.

Mr. Appleton. Excuse me, Congressman. To clarify the $45 million includes all our findings, whether or not we charge a larceny or other crime on their basis.

Mr. Pike. That is what I was afraid of. What you are saying is that every overpayment you have found, you have characterized as fraud. Now, the IRS does not do that; and it just seems to me that that is a rather dangerous approach to take. With regard to again putting it in perspective, that $45 million of all overpayments, whether fraudulent or not, represents what percentage of the total of payments that were made?

Mr. Appleton. Over the last 5 years, somewhat under 10 percent.

Mr. Pike. That is all.

Mr. Hynes. Just to point up, Congressman, whether you call it fraud or not, that is $45 million that will be recovered.

Mr. Pike. That may well be. My point is that you have got to make a distinction in simple fairness between fraud and error. There are things which are error.

Mr. Hynes. True. The category of nursing home operators that I spoke of before do not involve those people who put down for reimbursement expenses that they are not entitled to. These people put down expenses as if they were running their own candy store. This money is recoverable.

Mr. Blair. Also, Congressman, a lot of these costs are repetitive. In other words, there are cetrain things built into the rate reimbursement system which once uncovered are a continuing thing. If you never discovered it, the State would have paid another million and another million and another million. A lot of those things, you catch it in the beginning whether it is criminal or not, and it is taken care of.

Mr. Hynes. I am just sorry your facility is not used a little more as a model.

Mr. Pike. May the record show there was applause at that point.

Mr. Rostenkowski. Mr. Ford?

Mr. Ford. Thank you, Mr. Chairman.

I have one question. How is it that a claim for reimbursement can be approved when it includes a laundry list of items that do not qualify for reimbursement? Items like interior decorating, for example.

Mr. Hynes. Congressman Ford, they never listed it as interior decorating. It is listed as physical therapy in some instances. The paintings by Matisse and Renoir from the Hollander case were listed as laundry expenses. It was only after our investigators went to the vendors, after checking the books and records of these homes, that we found the items that are listed in this laundry list.

Mr. Ford. Are you telling me that items such as a political contribution would not be listed on the claim, but would be shown on the organization's books?

Mr. Hynes. That is what I am telling you. By the way, in fairness, there is absolutely no question that the public officials who received the money and philanthropic organizations—or rather the charitable organizations that received the money, there is no question in my mind that they had no idea this was being reimbursed by the claim.

Mr. Ford. This happened on medicare claims?

Mr. Hynes. Medicaid.

Mr. Rostenkowski. Mr. Scheuer?

Mr. Scheuer. Thank you, Mr. Chairman. Well, Mr. Hynes, you have done it again.

You were the star performer at our hearings on medicaid fraud and abuse last year in New York City, and you have given us an outstanding statement today, in my view one of the clearest and most persuasive statements on this subject that I have heard.

As you may recall, you emphasized a year ago at our hearings, the difficulty that the States face, particularly the State of New York in its state of financial pressure, if not crisis, in allocating funds sufficient to put together this very sophisticated team of experts with the computer backup and so forth.

You said that some kind of help was needed. As a result of your testimony in large part, I put together a program that I think you are familiar with. Where a State chose to set up an independent investigative and prosecuting office for medicaid and medicare fraud, free standing and independent from the service agencies, with the kind of diverse professionalism that you described and typified as a team approach, and reporting regularly both to the State and to the Federal Government, that such a unit would get 90 percent funding for the first 3 years and 75 percent funding after that.

We are also considering adding to that a provision that the Federal Government would remit for the first 3 years, or forgive for the first 3 years, its share of any recoveries to provide an additional little boost.

Can you give us in some detail your reaction to that kind of an addition to this amendment?

Mr. Hynes. Well, I think it is enormously helpful not only to the States we have dealt with but to New York State. We, as I indicated, are about at the level where this investigation is not only paying for itself but it is making money for the State. I see no reason why we should be penalized because we developed the program. We would certainly like to get some help from the Federal Government initially.

Particularly if there is a need to expand into other areas of medicaid fraud as I believe there is. As to the other States, it would be enormously helpful. We have run a training seminar for a number of States who have come in and seen the kind of program we have had. We are very excited about the prospects of beginning such an investigation; and the calls back were very depressing, that they simply could not get any money from their State government to set up this kind of investigation. I do not know how widespread they are, but there is certainly enough evidence from the States we have dealt with, more than a dozen, to indicate that New York does not have any peculiar monopoly on the problems of medicaid. They certainly exist elsewhere.

Mr. Scheuer. And no particular need that is not shared also by other States?

Mr. Hynes. That is right, yes.

Mr. Scheuer. I take it you have a very sophisticated computer backup?

Mr. Hynes. Yes, we do.

Mr. Scheuer. Why in your opinion has it taken us 12 years to get to the point where we are finally harnessing our technology to police the program that has been obviously in need of policing for a long time?

Why has it taken the federal Government so long?

Mr. HYNES. I can only speak for New York State. I do not think anyone measured the problem, Congressman, until 1974, September of 1974, and no one really understood the dimensions of the effort needed to deal with these problems. Yet we had been obviously warned—warned 17 years ago in the Kaplan report.

Then they put in certain administrative changes. What they forgot was enforcement. As a result, we had the repeated scandal cycle.

Mr. SCHEUER. Did you get your computer program, your computer model from HEW or did you develop it yourself?

Mr. HYNES. We developed it in-house.

Mr. SCHEUER. Is it superior—how would you compare it to the computer model that HEW is using?

Mr. HYNES. At the risk of having a problem with HEW, I would rather pass that question. We think it is a better program.

Mr. BLAIR. Congressman, what happened—why we developed this was the reimbursement claim forms were set up so they could be put on a computer; and we assumed that you could use audit techniques, do some comparative analysis. They did not have any.

They still have not gotten it in our own State. That is the only thing we can judge it on. The interest seems to be on the doctors; and that type of providers. No one seems to be—at least as a priority item—to be interested in institutional providers.

So therefore, it was as kind of a defensive mechanism that we developed this computer. Everyone wanted to get the doctors, the profiles of the patients, that kind of thing which is very complex and takes a long time.

Mr. SCHEUER. Thank you very much.

Mr. ROSTENKOWSKI. Mr. Martin will inquire.

Mr. MARTIN. Mr. Hynes, perhaps you were here when we were discussing some of these questions with the Secretary of HEW.

Mr. HYNES. I was.

Mr. MARTIN. You remember I asked his opinion about suggestions that certain requirements be imposed on the States and that certain structural changes be made in the Justice Department. Perhaps you wondered where I got the idea. Of course, the answer is that while he was being questioned by others, I was reading an advance copy of your statement and thought well enough of the suggestion, that same suggestion which you advanced in that statement that I thought it would be well to get his opinion and get dialogue on that.

Do you recall that in response he expressed the view that we should not impose these kinds of requirements on State Governments; and it would be helpful if you might respond.

Mr. HYNES. The only analogy that comes to mind, Mr. Martin, right now is what happened in the LEAA funding. What we thought we would get—and I speak now as a citizen—what we thought we were giving to States was the kind of expertise and the moneys to train people and—to develop new programs, to increase the war against crime.

I think what we got was a bunch of personnel carriers, you know, tommyguns, and a whole raft of stuff that was not as necessary as the other problem.

What I think is absolutely necessary is that standards must be—absolutely necessary that standards must be defined and that if a State wants to get involved in this problem of medicaid prosecution, and if their complaint has been we have not been able to because we don't have the money, the Federal Government ought to impose a set of standards in my judgment.

Mr. MARTIN. And provide financial assistance?

Mr. HYNES. Yes. It does not force a State to join the program. It is up to the State to come within the standards.

Mr. MARTIN. As I understand it, in your operation that you have set up in your unit, you have the combined talent within that unit of prosecutors, investigators, accountants, auditors all working in one group rather than having to borrow from other offices why may have other priorities. I got the impression that the Secretary was saying he would be opposed to having special units, with the concept of having special units set up.

I thought you might respond to that as to the way in which that has or has not facilitated your investigation.

Mr. HYNES. It is perhaps that the Secretary and I have different backgrounds. I have been a criminal lawyer for 15 years. I practiced half that career on the other side of the well, as a defense lawyer. What I did find as a prosecutor—and everyone has their own set of horror stories—you get a call from an agency head, from the motor vehicle bureau who will tell you, I have the greatest case that has come down the road in 10 years; and he would come in with these files about a stack so high. In 3 minutes, the glaze would come over your eyes. You would fall asleep.

The problem is that unless you have the in-house coordinated team effort, which has investigators, auditors, lawyers, to coordinate themselves, you are never going to get even a properly-funded local office to handle this kind of investigation for a simple reason: the priority which gets people elected every 4 years is street crime, organized crime, corruption cases.

It is very, very difficult, you know, to get local prosecutors involved in this kind of investigation.

Mr. MARTIN. Well, let me thank you for the suggestions that you have made and for your testimony. There are—I hope the majority of us will try to incorporate these into the package.

You have to understand although we do have two subcommittees from different committees working together in these hearings some of the discussions may involve other committees' jurisdictions. I think if we can raise these and push for these recommendations, we may find that the other committees will then be more than willing to help us to incorporate them.

Mr. HYNES. Thank you.

Mr. ROSTENKOWSKI. Mr. Maguire will inquire.

Mr. MAGUIRE. Thank you, Mr. Chairman.

Mr. Hynes, I appreciate your statement, as all members of the committee do. I expect that you probably know more about this subject that most anyone in the country. I do however wonder if you have any comments on the bill that is before us by way of giving us any additional guidance on the bill which you did not choose to do in your opening statement?

Mr. HYNES. I was mainly interested, Mr. Maguire, in two items, one in the bill already and the other one is Congressman Scheuer's amendment. There is no question in my mind that the penalties for kickbacks are woefully inadequate, both in New York State and on the Federal level. I would certainly hope that the committee will amend the bill to increase the penalties.

Mr. MAGUIRE. Mr. Skinner made a suggestion with respect to penalties. The bill provides that providers should be charged with felonies rather than misdemeanors, which is an upgrading of the penalties; but Mr. Skinner felt that it would still be useful to have a misdemeanor option. Would you share that view?

Mr. HYNES. No, I do not. I disagree.

Before I was appointed to this job, I was in charge of the rackets bureau in the King's County district attorney's office. We had a policy there which I brought to this office that we do not plea bargain below felony level except in the rare instances where we can get some cooperation. That has been our policy. I think it is a good one. I think it squares on the question of deterrence. In my judgment, unless there is incarceration following these prosecutions, we are wasting our time.

Mr. MAGUIRE. Another suggestion that he made was that instead of requiring disclosure of ownership information only on request of the Secretary that that should be a mandatory disclosure requirement, annual filings, so on.

What would be your feelings about that?

Mr. HYNES. I confess I did not focus in on that part.

Mr. PIKE. Would the gentleman yield?

Mr. MAGUIRE. Surely.

Mr. PIKE. Don't we already have most of that in the State of New York?

Mr. HYNES. Sure, we do.

Mr. BLAIR. In New York, the forms they submit have all that information.

Mr. MAGUIRE. It is mandatory?

Mr. BLAIR. It is in the form to get reimbursement.

Mr. MAGUIRE. A projection of that statement to a national picture would presumedly suggest or imply that you might think that was the useful way to approach it nationally?

Mr. HYNES. I would have to give more thought to it.

[The information follows:]

ADDITIONAL INFORMATION REQUESTED OF CHARLES J. HYNES

After further consideration of your question, Congressman Maguire, as to whether or not the disclosure of financial and ownership information by medicaid providers should be made mandatory, I would reply that section 1124 of the proposed bill should be amended to require mandatory disclosure to both State and Federal agencies dealing with medicaid.

As I previously mentioned, New York State already requires such information be filed annually with the cost reports of health facilities that are seeking reimbursement. I understand that information is most helpful in analyzing reimbursement.

It is also impossible without having accurate information on ownership on related companies to be able to determine the actual costs or the actual profitability of an enterprise. Such information is obviously of critical importance to any State and to Federal Government in efforts to control costs and intelligently plan the allocation of resources to the health care system. Moreover, the process of licensing nursing home operators would be greatly improved is such information was routinely available to State and Federal licensing authorities. Many nursing home chains operate on the basis of concealed ownership and control with a different hidden partner as appearing on the public record for each particular facility. With proper disclosure, these individuals can be held responsible for the costs and care quality in all the facilities they are involved with.

Finally, such information is of obvious importance to any enforcement agency. Its availability makes enforcement quicker and easier, while the knowledge that all financial relationships have to be disclosed would in itself be an importance deterrent to unscrupulous providers and fraudulent practices.

However, I would add this warning: the value of any disclosure system ultimately rests on the availability of enforcement personnel able to utilize the information, and to check its accuracy. If provision is not made for enforcement the value of such standards will be sadly diminished and they would be first subtly and then openly evaded.

Mr. Maguire. Why, don't we hold the record open for that, Mr. Chairman?

One other question, do you have any views on the expense of PSRO's to give us at least the initial cut at trying to manage and eliminate fraud and abuse? Obviously, the investigative role needs to be strengthened very much. This bill hands this over to PSRO's in not only hospitals where they have had it but also in the shared facilities and nursing homes and so on. Do you have any comments on that? You may not. If you do not, that is fine.

Mr. Hynes. I think any quality review is a step forward. We have worked with certain advocate groups in New York State like the Gray Panthers and the friends and relatives of the institutionalized aged who have been serving basically as a watchdog, an ombudsman for the problem.

I think any kind of quality review steps are helpful. I have not really given that much thought to it.

Mr. Maguire. Thank you very much.

Mr. Rostenkowski. Mr. Brodhead will inquire.

Mr. Brodhead. Mr. Hynes, I wanted to ask you a question that perhaps is not really what you came here to talk about today. As I have listened to the testimony today, I have been wondering what is wrong with the way we here in Congress design these programs which allows these kinds of things occur. I just wonder what ideas you or members of your staff might have about how can we change the way we designed these programs so that there are at least, if not incentives to be honest, fewer incentives to be dishonest? Do you have any ideas on that?

What has gone wrong in the way we have set the thing up?

Mr. Hynes. I do not think it is something that anyone can see would happen when this marvelous humane program was set up many years ago. The problem was no one really thought very much about enforcement. They thought about regulation. We have done that consistently in the State of New York. We have all manner of regulations. It has been the lack of enforcement. What I suggest to you is that the amendment that Congressman Scheuer proposes will be an enormous step forward in curtailing future abuses by giving to the States the resources to put teeth in their enforcement capability.

Mr. Brodhead. Well, all right. That is fine. What we are talking about, then, is how to get back some of the public's money after it is gone; and we are talking about trying to punish people for doing something, or deter others from doing the same thing.

I have to think there must be a better way to write these programs, so these opportunities are not presented. I guess we are always going to need some enforcement; and certainly you have blazed the trail there; but I wonder if we would not all be better off if we did not have to spend $7 million a year for your office, maybe only $700,000 would be necessary.

We could take that other $6.3 million and put it into better patient care. I guess that is what I am trying to get at. Perhaps I am not directing this question to the right person. Still, I would like to know your thoughts or the thoughts of your staff on it.

Mr. Hynes. The $7 million in any sense should not continue forever. We will be completing the investigation on the proprietary nursing home industry by July. Then as I view it, nothing more than merely a bureau within the office would be necessary to make spot checks of the homes in the future.

We are going to be devoting a great many resources to the voluntary homes next, and to the public homes, and to the adult homes.

Again, going back to how you draw regulations, Congressman Brodhead, you and I will be dead three days and people will still steal. There is just no way of passing a law to make people stop stealing. What you have to do is put good tough enforcement mechanisms in any of these social programs. I do not think we have done that.

The State is as much at fault as the Federal Government, maybe more so, because they are the ones that contribute the money at the local level.

Mr. Brodhead. If I understand what you are saying then, you do not feel that there is anything basically wrong with the way the programs are designed, but what is lacking is some kind of oversight to assure that abuses do not occur. If we were to start all over again and rewrite the program, we should just rewrite it pretty much the same way?

Mr. Hynes. But insist upon standards within the States which are the recipients of the dollars. Insist on rather well-defined standards. You cannot administer a billion dollar nursing home program and regulate it with four auditors. We had 16 auditors for 2,400 homes. Four of those were working on nursing homes. That just does not make any sense.

You are inviting theft. Many people picked up the invitation.

Mr. Scheuer. Will the gentleman yield on this question?

Mr. Brodhead. My time has expired.

Mr. Scheuer. So please yield.

Mr. Brodhead. I will yield.

Mr. Rostenkowski. His time has expired.

Mr. Scheuer will inquire.

Mr. Scheuer. On the question of the forms and the reporting requirements and the pieces of paper that are involved here, I take it that you have improved and upgraded the forms and the reporting reaquirements in New York State?

Mr. Hynes. We made recommendations in that area, sure.

Mr. Scheuer. You made recommendations to whom?

Mr. Hynes. The State Department of Health.

Mr. Scheuer. Have they put them into effect?

Mr. Hynes. In some instances, they have.

Mr. Scheuer. Are there certain adaptations or certain basic standards of reporting, basic uniformities in reporting that you would say HEW should mandate to the States so that as States begin to get into the kind of a sophisticated enforcement capability that you have developed. Such uniform systems together with applied computer technology could greatly help the fraud and abuse detection effort.

Mr. Hynes. Absolutely, Congressman. Absolutely. I think that is necessary.

Mr. Scheuer. Would you say that HEW now permits too much diverse and less sophisticated reporting than you deem necessary for the computer to be applied effectively to the investigation and identification of fraud?

Mr. Appleton. We would have to look into that in detail.

If you wish we could provide you a detailed response for the record, Congressman.

Mr. Blair. I think you should know, though, that the State of New York's form has gone from 15 pages to 87. There is a tremendous amount of information therein. It is mostly reactive; you find out something, you add another page. I do not think anyone has really conceived of coming up with a 40-page form that really accomplishes the same thing.

Mr. Scheuer. Do you think it could?

Mr. Blair. I think it probably could come up with a simpler form. It is fairly complex. We have never looked at that position because it is good from a prosecutorial point of view. There is a tremendous amount of information in there. It has gone from 15 to 47 and now next year may be 148.

Mr. Pike. Would the gentleman yield to me?

Mr. Scheuer. Yes; as soon as I finish.

We have to balance these two goals. We don't want to have all kinds of unnecessary burdens on legitimate entrepreneurs. At the same time, we need to provide a team like yours with the sophisticated inputs that that computer can take and then bounce back some red flags that you can follow up. Maybe you could give us a memo or a letter giving your ideas on the kind of uniform reporting and accounting and recordkeeping that you think the Federal Government ought to require the States to keep on these people and try and establish some compromise between everything that you need and a reasonable level.

I am delighted to yield the time.

Mr. Pike. You said what I was going to say.

[The information requested follows:]

ADDITIONAL INFORMATION REQUESTED OF CHARLES J. HYNES

In response to Congressman Scheuer's request for information on what uniform reports and accounting the Federal Government should require, I would begin by reminding the Committee that one of the main problems with reimbursing institutional health care providers is that their reimbursement is based on reported costs which are not uniform among the facilities seeking reimbursement. I feel that Uniform Accounting Standards are necessary in order to facilitate comparative analysis of similar types of facilities. Such analysis is easily done by computer systems, and will better enable responsible agencies to note trends in the industry being analyzed, as well as simplifying reimbursement administration.

Uniform Accounting Standards would provide specific guidelines for the accumulation and reporting of a facility's cost. This would make comparative analysis a viable management tool. Once such systems are developed they would be continually refined based on the results of computer analysis and feedback from field audits of selected facilities. The distinction between Uniform Accounting and Uniform Reporting is an important one to note in this context. Uniform Reporting has some of the characteristics of Uniform Accounting Standards, but it is by no means as effective. In New York State, the required reporting formats for residential health care facilities under State Medicaid regulations have been made so specific over the past few years that New York is close to having Uniform Accounting Standards for Nursing Homes. However, New York has not come close enough. These reporting requirements have been adopted in a piece-meal fashion—each new requirement being aimed at a specific problem. The result has been a lengthy, complex reporting form which was not developed in a cohesive manner. The regulations supporting these requirements are equally lengthy and complex.

The HE-2P form used by Nursing Homes in New York State currently asks for such statistical information as mortality rates, age and sex of patients, detailed information on admissions, discharges and lengths of stay, and detailed information regarding the ambulatory status of patients, including questions regarding how many patients require assistance in walking, eating, dressing, etc.

While all of this information may be relevant in attempting to assess the quality of care being provided to a facility, it is questionable as to how valuable this type of information is in determining what would be an adequate level of reimbursement. It is also questionable whether all of this information is so valuable that it should be requested annually of every facility in the State. What is needed is a more concise, cohesive reporting form limited to the information needed for reimbursement analysis. This would include financial and ownership information relating to the facility and its owners, as well as all non-arms length relationships which exist between the facility and any of its owners. It would also include certain key service delivery statistics such as patient days, bed capacity, amount and type of volunteer time donated to the facility, and other items which could have a direct effect on costs and reimbursement or which directly measure the quality and quantity of care delivered.

The financial information to be required would consist primarily of a balance sheet and income statement, with associated supporting schedules giving additional information on areas such as depreciation, capital balances and related companies. This is largely the same information that any facility would currently provide to stockholders, lenders, and/or to the Internal Revenue Service. Accordingly, these facilities would not be required to expend any noteable amount of extra effort in order to provide this information to State and Federal agencies.

Some additional detail would be requested which would not normally be shown on financial statements. This information would identify specific costs such as nursing payroll, medical supplies, dietary, housekeeping and linen expense, and other costs which are more or less unique to the operations of a health care facility. While this degree of detail would not normally be reported in a facility's financial statements, it probably would be recorded in detail on the facility's books. By devising Uniform Accounting Standards in concert with the required reporting forms, it would be a simple clerical task to extract the required information from the facility's books and records. This information should also be reported directly in the financial statements, not as supplementary information requiring duplication of effort on the part of the facility.

It is very important that all companies related to the health care provider by common ownership or control be required to disclose the nature and extent of such ownership or control, and also be required to submit the same basic financial information submitted by the health care facility.

These forms, as I envision them, would be developed in tandem with uniform accounting systems. The instructions would be keyed into the applicable rules and regulation. This might require some revision of existing rules, regulations and manuals. An example would be the HIM-15, which is HEW's Provider Reimbursement Manual and which now applies to general reimbursement of both hospitals and residential health care facilities.

With the development of Uniform Accounting Standards for each type of entity new manuals should be developed for each specific type of entity. This would facilitate the researching and implementation of regulation at the provider level. Such Manuals could be easily cross-referenced to the instructions accompanying the reporting forms.

We feel strongly that Uniform Accounting and Reporting Standards can be developed and implemented which would provide an adequate data base for reimbursement determinations, and which would also allow the application of computer techniques to identify possible areas of fraud and abuse. Additionally, we feel that these standards could be implemented without placing unreasonable demands on providers of health care. This would require relatively little additional effort on the part of health care facility, and would probably be no more than 20 or 25 pages.

In closing, let me draw your attention to the fact that the current computer systems for Medicaid, as they have been described to us, seem largely conceptualized in terms of the problems of individual providers. Individual providers are reimbursed largely on a fee for service basis. This is substantially different than the reimbursement for facilities which is based on a weighted average of costs. This makes the accounting and computer analysis requirements substantially different. This must be recognized if facilities are to be effectively controlled by Uniform Accounting Standards and the computer systems supporting them. Since 70% of Medicaid expenditures are payments to facilities, more attention must be paid to the particular requirements for controlling their costs.

Mr. ROSTENKOWSKI. Thank you very much, Mr. Hynes, Mr. Blair, Mr. Appleton. Thank you for your cooperation.

Our colleague, Congressman Pepper. We want to welcome you to the committee. I am sure, as is your usual custom, your testimony will be very enlightening.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA, AND CHAIRMAN, SELECT COMMITTEE ON AGING

Mr. PEPPER. Thank you, Chairman Rostenkowski and Chairman Rogers.

Since you are pressed for time and I am a bit myself, Mr. Chairman, I will ask if I may have my statement appear in the record and I will just hit the highlights.

Mr. ROSTENKOWSKI. Without objection, your statement will be in the record.

Mr. PEPPER. I appear as chairman of the Select Committee on Aging and Subcommittee No. 2, which has jurisdiction over health and long-term care. The people on our committee are tremendously interested in H.R. 3, which you are sponsoring. We hope you will have a favorable report from your committees and that the House will adopt it and it will become law in early time.

I think we all are aware of the fact that there has been an enormous increase in the cost of medicaid and medicare. These two programs are now costing Federal and State governments of the country about $40 billion a year.

We know also that it is estimated that by 1980 the cost of care generally of a medical nature for the people of this country will have doubled within the 5 years prior to 1980. So we are all also aware that we have much more to do than we have done heretofore to provide all the necessary health care of all sorts to the people of this country.

Every dime we can save which is now being wasted in fraud and corruption is just that much more of a contribution toward providing the health care that the people of this country need.

Now Congressman Koch and I introduced H.R. 453 upon which we have 60 cosponsors, which embodies the provisions you have in sections 3 and 8 of H.R. 3, whereupon we commend you, and that is that providers or suppliers under either one of these programs must disclose upon request anyone who has any more than a 5-percent interest in either one of those providers or suppliers.

We feel that people are entitled to know who are providers and suppliers of these essential services and functions.

The next point that we commend you on is the emphasis that you are putting on the clear intent of Congress, that medicaid be the payor of last resort where third parties, such as insurance companies and auto no-fault insurance programs, have an obligation to pay. This is the intent of the bill of which I am the author, H.R. 1128, which has been consponsored by 64 of our colleagues.

I am told that the Department of Health, Education, and Welfare estimates that between $200 million and $500 million could be saved each year through a vigorous program of collecting from third parties. This is primarily a responsibility of the States, and we urge that we keep the pressure, as it were, upon the States to exercise that function and try to carry out the intent of Congress that medicaid be the payor of last resort. In other words, States should make others contribute the share that they should contribute toward the cost of medical insurance.

Now, in addition to those two points, I have a bill, H.R. 1116, which has 73 cosponsors, which would expand the availability of home health services and provide three steps which I think might be considered toward making these cost-effective operations.

First, the bill would require home health service providers to have a utilization review plan along the lines as those now required of hospitals and skilled nursing facilities. This would assure that periodic assessment of need is carried out to provide for the most efficient use of scarce resources.

I think we are going to find more and more emphasis put on home health care—and properly so—as an alternative to institutionalization, and we want to be sure that there is no fraud or mismanagement or corruption in those meaningful and important programs.

Second, my bill would require an annual audit of the financial statements of home health agencies by an independent certified public accountant as a basis for cost-related reimbursement. The auditor's opinion would state that expenses of the agency are in conformance with allowable expenditures as authorized in HEW regulations and guidelines. This would insure that the financial statements are accurate, but more importantly, that the costs claimed in the financial report are legitimate, honest costs involved with providing health services.

This is an important concept, and one which deserves the careful consideration of your committees.

Moreover, our committee strongly recommended in a report last year that annual, unannounced on-site Federal audits of medicare and medicaid nursing homes should be required. These should be undertaken immediately, at least on a random basis. That report points out that there has been a "dearth of audits" of the Nation's nursing homes. The report pointed out that 20 States had not audited a single medicaid nursing home.

I quote from the report: "Testimony revealed that hundreds of thousands of dollars had been inappropriately spent in those that had been audited." I remember we held a hearing in Providence, R.I. Our attention was called to the fact that a Mercedes Benz car was used by the management, which we thought was a little bit of an expensive means of transportation and which would have to be taken out of the funds that should be available for the care of the people there. I am a cosponsor of legislation on that point with my colleague, Edward Beard, of Rhode Island, H.R. 1620.

Two other bills I have offered, H.R. 1116 and H.R. 1126, and H.R. 453 introduced by Representative Koch and me, have as their aim making payment to all health care institutions under both medicare and medicaid on a cost-related basis.

As you know, the Senate Finance Committee expressed concern that in the absence of statutory requirements, some long-term care facilities were being underpaid by medicaid while others were overpaid. Section 249 of Public Law 92–603, requiring reimbursement on a reasonable cost-related basis, resulted from that concern.

I believe that we should expand this concept. Not only will it save money, but it will also give the assurance that adequate funds are provided to support a high quality of patient care in health care institutions.

Third, I am pleased that the bill before you, H.R. 3, places emphasis on the role Professional Standards Review Organizations can play in eliminating and preventing fraud and abuse. The bills to which I referred earlier, H.R. 1116 and H.R. 1126, would go a step further and make it clear that long-term care facilities—as well as medical institutions—are to be subject to review by PSRO's. Moreover, my bills would require that nurses, social workers, guidance counselors, and other health professionals be included in PSRO's. Broader representation by these groups can only serve to enhance the PSRO system and assure a wide range of viewpoints. Once again, this has the support of the Aging Committee.

In conclusion, I commend my colleagues on these two important subcommittees of the House for their energetic approach to solving the very serious problem of fraud and abuse in our medical programs.

My committee and I are committed to do everything we can to assist you in these efforts. The money we save can and must be directed to making health care more readily available to all Americans.

These programs certainly are not perfect! But we cannot use that as an excuse to fall behind in the fight to provide the benefits we know our people need. Neither let us fail—because of our zeal—to require strict accounting of the money we spend.

An earlier American once said it in a way that applies to everything we try to do in a democracy: "The condition upon which God hath given liberty to man is eternal vigilance."

We don't have to have a trade-off between expanded health care on the one hand, and fraud and abuse on the other. And we don't have to tolerate corruption and mismanagement to press forward with our goal. Let's keep this in mind in the days ahead. Thank you.

Mr. ROSTENKOWSKI. Thank you, Senator. You have once again given us an enlighten statement. Are there any questions of Senator Pepper?

Mr. ROGERS. Mr. Chairman, may I say to my distinguished collegue from Florida that he has certainly given a helpful statement. Of course, we know of his dedicated interest in this whole area and fine work he has done on this Committee on Aging. We welcome your statement. It will be helpful to the committee. Thank you.

[The prepared statement follows:]

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Chairman Rostenkowski, Chairman Rogers, I appreciate the opportunity to speak in support of H.R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, which I have joined in sponsoring. As Chairman of the Select Committee on Aging, I have an abiding concern that these programs be something of which we can all be proud. I believe this bill can take us a long way toward restoring integrity and fiscal soundness to the Medicare and Medicaid programs, and I urge that it be enacted as expeditiously as possible.

Medicare and Medicaid have made health care possible for many millions of Americans. But the cost of providing this care has escalated year after year, reaching enormous proportion. In fiscal year 1976, Medicare cost the Federal government $17.8 billion. Medicaid cost Federal and State governments a total of $15.5 billion, and is projected to account for $18.6 billion in expenditures in fiscal year 1977.

Together, these two programs will cost Federal and State governments more than $40 billion this fiscal year.

Rising costs in these programs are symptomatic of what is happening in health care across the board. In 1975, Americans spent $108 billion for personal health care services. In 1976, they spent $126 billion. The Congressional Budget Office estimates that in 1980, it will be up to $224 billion—more than double in just five years.

The new Administration and the Congress are committed to a joint effort to slow down the unconscionable increase in health care costs. And it comes none too soon. The success of our efforts now will affect the quality and availability of health care in America for the rest of this century.

I offer this word of caution. Our efforts to pinpoint and end abusive or fraudulent practices must not be seen as a retreat from our commitment to assure Americans of good health care. Rather, they should be viewed as necessary to preserve these programs and bring about the expansion of benefits that are vital to the well-being of so many Americans.

I have fought, for example, and will continue to fight, for expanded coverage of home health care as an alternative to institutionalization of the elderly.

We will not retreat. We will not fold up our tents and steal away into the night. We simply owe it to beneficiaries and recipients—as well as the taxpayers who support Medicare and Medicare—to prevent fraudulent activities which bloat the programs and, in the end, prevent those who most need help from getting it. American taxpayers deserve to know that their tax dollars are being used in the wisest and most efficient possible manner. We intend to give them this assurance.

By the same token, Americans of every age and every income deserve access to quality health care at a price they can afford. These dual goals are central to our discussion here today. They must be the end result of our efforts.

I am pleased that the authors of H.R. 3 saw fit to include at least two proposals that I have advanced. The first, in sections 3 and 8, would require providers and suppliers under both programs to disclose, upon request, ownership interest of 5 percent or more. Congressman Edward Koch and I proposed disclosure in H.R. 453, which has 68 additional cosponsors. It was also recommended by the Subcommittee on Health and Long-Term Care, which I also chair, and by the full Committee on Aging last year. It is imperative that operations which involve Federal funds be carried out in the broad daylight.

Second, I commend the authors of this legislation for including, in section 11, a requirement reaffirming the clear intent of Congress that Medicaid to the payor of last resort where third parties such as insurance companies and auto no-fault insurace programs have an obligation to pay. This is the intent of my own bill, H.R. 1128, which has been cosponsored by 64 of our colleagues.

The Social Security Act requires each State to take all reasonable measures to determine the legal liabilities of third parties to pay for covered medical services. The Department of Health, Education and Welfare estimates that between $200 and $500 million could be saved each year through a vigorous program of collecting from liable third parties. Yet HEW State audit agency reports have proved that recovery programs by the States are sadly lacking. And several States have enacted laws, primarily automobile no-fault insurance programs, which serve to make Medicaid the primary payor, rather than payor of last resort as intended by Congress.

Medicaid costs the States—not just the Federal government—a great deal of money. The States should recognize that it is in their own interest to seek out other parties which have responsibility to pay for medical services that otherwise deplete state budgets. I have urged, and will continue to urge, that HEW emphasize the necessity that State comply with this important legal requirement.

In addition to the provisions for disclosure of ownership and third-party liability, I would briefly describe other ways I have proposed to bring costs under control. My bill, H.R. 1116, which 73 cosponsors, and which seeks to expand the availability of home health services, provides three steps I believe we should take to insure honest and cost-effective operations.

First, the bill would require home health service providers to have a utilization review plan along the lines as those now required of hospitals and skilled nursing facilities. This would assure that periodic assessment of need is carried out to provide for the most efficient use of scarce resources.

Second, it would require an annual audit of the financial statements of home health service agencies by an independent certified public accountant as a basis for cost-related reimbursement. The auditor's opinion would state that expenses of the agency are in conformance with allowable expenditures as authorized in HEW regulations and guidelines. This would ensure that the financial statements are accurate, but even more importantly, that the costs claimed in the financial report are legitimate, honest costs involved with providing health services. This is an important concept and one which deserves the careful consideration of your committees.

Moreover, our committee strongly recommended, in a report last year, that annual, unannounced, on-site federal audits of Medicare and Medicaid nursing homes should be required. These should be undertaken immediately, at least on a random basis. That report points out that there have been a "dearth of audits" of the Nation's nursing homes. The report pointed out that 20 States had not audited a single Medicaid nursing home. I quote from the report: "Testimony revealed that hundreds of thousands of dollars had been inappropriately spent in those that had been audited."

I am a cosponsor of legislation introduced by my colleague on the Committee, Edward Beard, to require these audits, H.R. 1620.

Two bills I have offered (H.R. 1116 and H.R. 1126) and H.R. 453, introduced by Representative Koch and me—have as their aim making payment to all health care institutions under both Medicare and Medicaid on a cost-related basis.

In the 92nd Congress, the Senate Finance Committee expressed concern that in the absence of statutory requirements, some long-term care facilities were being under-paid by Medicaid while others were over-paid. Section 249 of Public Law 92–603, requiring reimbursement on a reasonable cost-related basis, resulted from that concern. I believe that we should expand this concept. Not only will it save money, but it will also give the assurance that adequate funds are provided to support a high quality of patient care in health care institutions. I believe we must emphasize this goal in all our future deliberations.

Third, I am pleased that the bill before you, H.R. 3, places emphasis on the role Professional Standards Review Organizations can play in eliminating and preventing fraud and abuse. The bills to which I referred earlier, H.R. 1116 and H.R. 1126, would go a step further and make it clear that long-term care facilities—as well as medical institutions—are to be subject to review by PSROs. Moreover, my bills would require that nurses, social workers, guidance counselors, and other health professionals be included in PSROs. Broader representation by these groups can only serve to enhance the PSRO system and assure a wide range of viewpoints. Once again, this has the support of the Aging Committee.

In conclusion, I commend my colleagues on these two important Subcommittees of the House for their energetic approach to solving the very serious problem of fraud and abuse in our medical programs.

My committee and I are committed to do everything we can to assist you in these efforts. The money we save can and must be directed to making health care more readily available to all Americans.

These programs certainly are not perfect! But we cannot use that as an excuse to fall behind in the fight to provide the benefits we know our people need. Neither let us fail—because of our zeal—to require strict accounting of the money we spend. An earlier American said it in a way that applies to everything we try to do in a democracy: "The condition upon which God hath given liberty to man is eternal vigilance."

We don't have to have a trade-off between expanded health care on the one hand and fraud and abuse on the other! And we don't have to tolerate corruption and mismanagement to press forward with our goal. Let's keep this in mind in the days ahead.

Thank you.

Mr. ROSTENKOWSKI. Thank you, Senator.

Mr. PEPPER. Thank you very much. We appreciate it, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Koch.

We once again want to welcome you, Mr. Koch. As is your custom, you always brighten our day and bring to us important words with regard to the health community.

STATEMENT OF HON. EDWARD I. KOCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. KOCH. Thank you, Mr. Chairman.

I would like to file my total statement and then comment on matters which I think may not have been raised.

Mr. ROSTENKOWSKI. Without objection, your entire statement will be included in the record.

Mr. KOCH. I am, as you all know, very interested in the subject of home health care, medicare, medicaid, and the abuses therein which have become so prevalent across the country. We have had investigations in the State of New York. Joe Hynes, who has appeared here, is a special prosecutor in New York who was appointed because of the matters that were revealed several years ago.

Indeed, I was one of those who worked with the Senate committee that came up to investigate the nursing home situation and cross-examined Dr. Bernard Bergman who ultimately went to jail. I was very proud and pleased to have been one of those who interrogated him and brought out the evidence that was helpful in sending him there.

The problem is bigger than Dr. Bergman, however. It spreads across the country. Some of it is incompetence, some is fraud, some is the law. In this case the law in some areas is—as I think Charles Dickens' character, Mr. Bumble, described it, an ass. Let me point out what I mean by that.

In the city of New York they tried very hard to deal with the problem that laboratory fees were getting out of hand. A decision was made to ask people to bid on handling urine analysis and other laboratory problems that are required to be treated. They found that the laboratories that wanted to bid would provide total service to the city of New York for $5 million, whereas in fact the city of New York was paying out $12 million to individual laboratories charging those additional rates for the urine specimen analysis sent by physicians to individual laboratories.

When the city of New York asked HEW couldn't they contract out to save $7 million, HEW said, no, you can't do that. Freedom of choice.

The law prohibits the city of New York from saving $7 million, of which half would be a saving to the Federal Government, $3.5 million. In various other contractual services, whether it is drugs or laboratory services, the estimate is that—there was an estimate provided by a consultant to the comptroller of the city of New York that there would be a saving, just in the city of New York, of $37.5 million.

The Department of HEW said, no, you can't do it. It is because the law prohibits any such kind of contract bidding and requires what is referred to as freedom of choice.

Now, do we really think that a patient cares which laboratory examines his or her urine? That is not freedom of choice. I would suggest to the committee that you look into that question of removing that absolute prohibition which prevents a locality from entering into a contract that saves millions. That is No. 1.

A second area: We, under our medicaid program, allow an individual covered by medicaid to go to any doctor he wants to. The Federal Government pays for it.

Well, if a medicaid patient decides that he doesn't like this doctor, doesn't like that opinion, he goes to another doctor, goes to a third doctor, goes to a hospital. A middle-class person couldn't do that. A middle-class person who pays the bill himself or herself, many times won't go to the doctor rather than pay the $15 or $25 fee.

They certainly don't shop around to two or three doctors, but the medicaid patient can do that.

There has to be some system where a medicaid patient is assigned for primary care to a physician. That doesn't mean that you can't change your physician, but before you can go out and get three or four doctors to treat you, you ought to have at least the requirement that the primary physician to whom you are assigned says, yes, you need additional consultation.

Then we have a system, title XVIII, title XIX, medicare/medicaid, which is ridiculous. In the State of New York medicare and the nursing homes that are subject to medicare regulations are subject to much higher regulation than are those that only take medicaid patients, and there are homes in the State of New York, I am informed, that refuse to take medicare patients, but will only accept medicaid patients, because medicare patients, once they have accepted them, are entitled to a higher standard of care in terms of the very facilities. So why get invoveld with that when you have enough medicaid patients where the regulations are not so stiff?

So there ought to be a uniform standard. The medicaid facility is not examined so closely as is the medicare facility, because it doesn't come under the direct supervision of the HEW regional representative. I discussed this with them and is is my conclusion that there ought to be one standard. After all, it is the Government's money. Whether it is the Federal Government 50 percent or 100 percent, the other 50 percent under medicaid is city and State funds. It is still tax dollars.

There are two other matters I would also like to discuss. Recently, I held a hearing in New York on health and hospital corporations which spend over $1 billion. One of the facts we ascertained was that included in the medicaid rate paid to the doctors from the voluntary hospitals, who are on contract to work in the municipal hospitals under what we call affiliation agreements, are tuition fees for the doctors' children to go to college, as well as art classes for nurses and staff.

Now that is not the fault of the municipal hospitals, because that same provision is in the contract which those doctors have with the voluntary hospitals and they, too, get medicaid.

Why in the world should the taxpayer subsidize college tuition fees for the children of doctors? Why? This is ridiculous! Or art classes and poetry classes for medical staff! There is no question that what I am telling you was ascertained at the hearings and admitted to be true.

Finally, the Department of HEW relies on reports prepared by the Joint Commission on the Accreditation of Hospitals which assesses the operating efficiency of hospitals. Blue Cross has a contract with the Federal Government which gives to Blue Cross the responsibility of reviewing the financial operations of the hospitals, and it is based on the Blue Cross reports that the medicaid rates are computed.

Those reports—that of the Joint Commission on the Accreditation of Hospitals and the Blue Cross reports—are not public.

I must say that as a result of my having taken the matter up with the HEW, as opposed to the State and the city, where I couldn't get to first base, HEW has now directed that at least the Blue Cross reports be made public so people can be aware of those hospital costs.

So far as I know, the reports of the Joint Commission on the Accreditation of Hospitals is still a secret report. Why should it be secret? Why shouldn't that be subject to public scrutiny? So I am urging that since most of these institutions are funded with Federal moneys, you impose the sanction that any kind of contract entered into with the Federal Government in this area that we are discussing be made subject to public review.

On that note, I will close.

[The prepared statement follows:]

STATEMENT OF HON. EDWARD I. KOCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, as you know, the enactment of the Medicare and Medicaid programs in 1965 has had a profound impact on the administration and delivery of health services in this nation. In providing nationwide health insurance to the aged and certain disabled individuals, Medicare reaches almost 20 million persons in the United States. And the state-operated and administered Medicaid program insures that thousands more are guaranteed adequate health care.

The benefits of these programs have not come without considerable expense of government monies. The United States spends $116 billion, or nearly 8.3% of the Gross National Product on health care. This expenditure has been rising at an annual rate of 10.3% over the last 15 years. Medicare outlays for Fiscal Year 1977 are expected to reach 22.0 bilion, which is a 23.5% increase over the $17.8 billion that was spent in 1976. Similarly, Medicaid outlays will increase from $14.3 billion to $16.6 billion in the coming year, an increase of 13.1%.

These costs are adding to the financial plight of our cities and states, and as health care costs rise, the burden on these localities increases. We must closely examine the Medicare and Medicaid program to see which administrative changes would make the system more efficient and economical, while insuring equity and quality in health care.

With all of these concerns in mind, I became a co-sponsor of H.R. 3, which would provide much needed reforms in the accountability of our health programs. By requiring disclosure of ownership and business transactions, upgrading the fraud penalties to felony status, giving the Government Accounting Office subpoena power, and strengthening the organization of PSRO's, the bill goes a long way in correcting many of the problems that currently plague the Medicare/Medicaid program.

I am also very much in favor of the Section 2 provision that clarifies the ban on the use of factoring arrangements in payments to physicians. Factoring has contributed heavily to increased Medicaid costs in New York City, and the reinforcement of this ban would do much to stem the inflation of physician charges for Medicaid services.

If the states are to deal effectively with fraud and abuse in their Medicaid claims processing, it is imperative that a provision such as Section 7 be instituted. Offenders in the provider services must be prosecuted and suspended from participation in the programs. In addition, providers suspended in one program must be prevented from practicing or participating in the same program in another state. As one possible addition to Section 7, I would like to suggest the institution of a central recordkeeping system that would list the names of those who are found guilty of fraud and abuse. In addition, such a system could contain information on effective plans that are used from state to state, which would aid states in their attempts to establish new programs.

In addition, Section 10 of H.R. 3 serves to bring about the possibility of increased cost-control. As you know, Medicare recipients receive an explanation and notice of all claims paid on their behalf by fiscal intermediaries. This Medicare provision has assisted the authorities in checking on provider fraud, for many receipients will question the bill and will bring any irregularities to the attention of the proper authorities. I see no reason why this system should not be incorporated into the Medicaid program. However, I would suggest that the explanation of benefits information be extended to all persons participating in the Medicaid program, and not just to a sample group.

H.R. 3 is an excellent piece of legislation, and I will do all I can to help make it become law. However, I must add that I feel the bill does not go far enough in addressing some of the areas that must be dealt with if we are in fact going to improve the administration of these programs.

One area I would like to bring up that is not covered by H.R. 3 is the freedom of choice provision of the Medicaid law. The freedom of choice provision permits Medicaid recipients to choose their medical service provider. An admirable concept indeed. However, it has left the states with little or no mechanism to insure that medical services are delivered by providers who offer the best care at the lowest cost.

The freedom of choice provision not only applies to primary care physicians, but it has also been interpreted by the Federal government to allow medical providers complete freedom in choosing other providers with whom they contract for such ancilliary services as laboratory work. In New York City, this interpretation has encouraged excessive and inappropriate utilization of ambulatory care by patients covered by Medicaid. Unnecessarily high Medicaid expenditures for ambulatory care result from the inappropriate provision of such care by hospitals and physicians.

Indiscriminate utilization of ambulatory care for Medicaid patients in New York City has led to a disproportionate amount of visits per capita in the area. New York City's 1.4 million Medicaid enrollees averaged 7.5 per capita visits in 1975, a rate of 50% above the national average. Because of the freedom of choice provision, fifty-five percent of Medicaid reimbursed ambulatory care visits in New York City were made to hospital based clinics and emergency room, which have a higher cost base and therefore higher reimbursement rate than do private physicians. The nationwide average for such visits is 10% of Medicaid visits.

A recent report prepared by Richard Nathan of New York City, an expert and consultant in the health care field, stated that $37 million could be saved annually in New York City if the freedom of choice provision were waived.

Another area where there has been abuse caused by the unchecked use of the freedom of choice provision is the contracting out of ancilliary services such as lab tests. New York City offered a proposal to DHEW, which if implemented would have restructed the organizational patterns and financing mechanisms of New York City's clinical laboratory facilities. The proposed program would have been based on competitive bidding, and would have given one lab in each of the five boroughs exclusive rights to process Medicaid lab samples. This plan would have replaced the current method of service reimbursement. The cost of this program would have been $5 million annually, with the City having the option of renewing the contract at the same price for three additional years. At present, the City of New York pays $12 million in lab service fees to Medicaid. If the proposal had gone into effect, the City, State, and Federal government could have shared the annual $7 million savings accrued by New York alone. However, the DHEW ruled that the principle violated the freedom of choice provision, and in fact took the City to court and won. So, despite the potential cost-savings that would be accrued from consolidation of some ancilliary services such as lab tests, liberal interpretation of the freedom of choice provision serves to contribute to the rising cost of the Medicaid program.

I am not suggesting, however, that the freedom of choice provision be entirely eliminated from the Medicaid program. Most states, and in particular those states with extensive rural areas and small physician populations, have no difficulty operating under its provisions. I do believe that the Secretary of HEW should be given authority to waive the freedom of choice provision for those local authorities who demonstrate a reasonable need for such a waiver, and who can prove the cost-effectiveness and viability of their proposed alternative to freedom of choice services.

I have one more suggestion that I believe would strengthen the anti-fraud provisions of H.R. 3. I believe it should be required that any reports on costs or efficiency that are prepared for the Department of Health, Education, and Welfare should be made available for public scrutiny. Presently, the Department relies on reports prepared by the Joint Commission on the Accreditation of Hospitals which assess the operating efficiency of hospitals. Since these reports are prepared by a private organization, they are not released to the public. Similarly, the federal government contracts out to the local Blue Cross/Blue Shield corporations the responsibility of reviewing the financial operations of hospitals. In the case of the Blue Cross/Blue Shield reports, I am happy to state that I recently obtained a ruling from the local HEW authorities permitting the release of these audits into the public domain. I am appending for the information of the Committee the correspondence that led to this ruling. In order to insure that public scrutiny of such documents is the case throughout the country, I urge the Committee to add a provision to H.R. 3 requiring such releases. These records would greatly assist consumer groups and other concerned organizations in their efforts to publicize inefficiency and the lack of quality standards in health services.

In conclusion, Mr. Chairman, the poor and elderly have benefit enormously from the Medicare and Medicaid programs. However, the issues of management, quality control, and cost inflation threaten to jeopardize these gains and dilute the benefits of the programs. H.R. 3 is a most important step in remedying problems that plague the Medicare/Medicaid programs. Thank you very much.

State of New York,
Department of Health,
Albany, December 20, 1976.

Hon. Edward I. Koch,
Congress of the United States,
New York, N.Y.

Dear Ed: Our discussion last Friday about access to audits of hospitals prompts me to seek your assistance in obtaining Federal approval to treat such reports as public information.

Under the state Freedom of Information Law, field audits of health facilities are available to the public. Nursing homes are audited directly by my staff, or by the Office of the Special Prosecutor. In either event, the audit reports are made available for public inspection. This same principle applies to all audits conducted by my staff.

Hospital audits have been handled for Medicaid purposes, by contract with the Blue Cross Plans in New York State. The contract approach was decided upon because Blue Cross was already auditing for Medicare and its own purposes. A joint audit program for hospitals, with cost sharing among the three major third party payers, makes sense. To test the validity of our contract audits, we conduct our own examination of a number of hospitals.

However, Medicare has prevented us from making the joint audits available to the public on a routine basis. This result occurs because of the confidentiality position taken by Medicare as to its audits, which of course can not be separated when a joint audit is involved. There has been some liberalization of the Medicare position, but not enough to permit me to make hospital audits routinely available.

We are not able to achieve full disclosure in the face of the present Federal position. Perhaps you can be instrumental in changing the Medicare policy. Without your assistance or other intervention, full public access to hospital audits is not available.

Sincerely yours,

Robert P. Whalen, M.D.,
Commissioner of Health.

Congress of the United States,
House of Representatives,
Washington, D.C., December 28, 1976.

Thomas T. Tierney,
Director, Bureau of Health Insurance, Social Security Administration, Social Security Headquarters Building, Baltimore, Md.

Dear Mr. Tierney: Enclosed is a copy of a letter that I have recently received from Robert Whalen, the New York State Commissioner of Health.

According to the letter, the New York State Freedom of Information Law requires that audits of health care facilities that are conducted by state employees be made available for public disclosure. In fact, I recently completed an investigation of the New York City Health and Hospitals Corporation. The audits of Medicaid expenditures proved to be extremely valuable in assisting my analysis of the Hospitals Corporation. However, when I attempted to obtain Medicare-Medicaid audits of the voluntary hospital sector I was informed by Commissioner Whalen that those reports although prepared under contract by Blue Cross with the federal and state governments, where not available for public disclosure. Dr. Whalen indicated that he would like to make the reports available but had been prevented from doing so because of a "confidentiality position taken by Medicare as to its audits".

The defenders of the Health and Hospitals Corporation reacting to any criticisms of their operation, always state how unfair it is to attack the Hospitals Corporation whose records are completely available while not subjecting the voluntary sector to the same criticisms because their financial records are not available to the public, although filed with federal agencies. To illustrate, one can comment on the salaries and other benefits paid to the administrators and medical staff at the municipals because their salaries and fringe benefits are a matter of public record. However, one can not determine what the salary levels and fringe benefits are for these same individuals in the voluntaries, whole salaries are paid for primarily from public funds, because those figures are not available to the public. In my opinion this is wrong and should be corrected immediately.

In view of the fact that Blue Cross is appointed by you under contract to audit the voluntary and all other hospitals receiving Medicare funds. I believe it is incumbent upon you to make available to the public these reports and I request that they be made available to me forthwith.

Indeed, I believe that the proper business of Blue Cross is of a technical services nature such as claims processing and the allocation of public revenues and the auditing of those allocations is a governmental function.

Please direct your response to my New York office.

Sincerely,

EDWARD I. KOCH.

Enclosure.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
New York, N.Y., February 17, 1977.

Hon. EDWARD I. KOCH,
Member, House of Representatives,
New York, N.Y.

DEAR MR. KOCH: This is in response to your letter of February 7th concerning the public disclosure of Medicare-Medicaid audits and whether the Medicaid portion of these audits are available for public inspection.

We are in complete agreement with the letter of January 27, 1977 sent to you by Mr. Theodore Shulman, Deputy Regional Medicare Director, Bureau of Health Insurance, on the release of BHI audits.

The release of Medicaid audits is determined solely by the requirements of the Freedom of Information Act (5 U.S.C. (b)). Exemptions pertinent to Medicaid audits are contained in 5 U.S.C. 552 (b)(4) and (5). These sections relate to confidential commercial and financial information and intra-agency memoranda respectively.

If you have any further question, please do not hestiate to contact me.

Sincerely yours,

WILLIAM TOBY,
Regional Commissioner.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
New York, N.Y., January 27, 1977.

Hon. EDWARD I. KOCH,
Member, House of Representatives,
New York, N.Y.

(Attention: Mr. Victor Botnick).

DEAR MR. KOCH: Your letter to Mr. Tierney concerning the release of Medicare audits of voluntary and private hospitals has been referred to this office. I apologize for the delay in responding.

I was concerned to learn of the difficulties you have encountered in attempting to obtain these audits. Apparently both the New York State Department of Health and Blue Cross and Blue Shield of Greater New York have misconceptions concerning the release of Medicare audits. We therefore plan to discuss this matter with them in the very near future.

Generally, Medicare cost reports and audits, with certain possible exceptions, are disclosable. This information may encompass five types of documents:

(a) Statement of costs. (The cost report submitted by the hospital.)
(b) Adjustment report, resulting from the intermediary's "desk audit".
(c) Memorandum stating the auditor's opinion of the reasonableness and allocation of costs.
(d) Audit workpapers.
(e) Revised statement of costs, reflecting adjustment determined during the audit.

Obligations concerning the release of these documents are determined solely by the requirements of the Freedom of Information Act (5 U.S.C. 552 (b)) as interpreted by the Department of HEW Public Information Regulation (45 C.F.R. Part 5) and the Social Security Administration Regulation No. 22 Subpart E (20 C.F.R. Part 422). Therefore, these documents must be disclosed unless one of the exemptions to the Freedom of Information Act applies.

The only exemptions pertinent to the subject materials are 5 U.S.C. 552 (b)(4) and (5) which relate respectively to commercial and financial information which is confidential, and intra-agency memoranda.

However, it must be emphasized that the Freedom of Information Act does not require that material to which an exemption applies be withheld, but leaves to agency discretion the question of whether to disclose exempt materials. In fact, HEW policy is that records must be disclosed where there is no compelling reason for withholding. Thus, we must make a determination on a case-by-case basis, as to whether any information contained in these documents could be withheld. Because of this, it is Social Security Administration policy that Medicare audits be disclosead only by the regional offices of the Bureau of Health Insurance.

In addition, 20 C.F.R. § 422.435 (c) states that: "upon request in writing, cost reports submitted by providers of services pursuant to section 1815 of the [Social Security] Act to enable the Secretary to determine amounts due such providers [shall be made available to the public]."

It is the opinion of our general counsel that this section requires *full* disclosure of the statement of costs (document "a") and the revised statement of costs (document "e").

I hope that this clearly describes our policy with respect to the release of Medicare audits. If you have any further questions or wish access to audits for specific hospitals, please feel free to contact Steve Shaw of my staff on 264-4788.

Sincerely yours,

THEODORE SHULMAN,
Deputy Regional Medicare Director.
Bureau of Health Insurance.

Mr. ROSTENKOWSKI. Thank you very much again. You are always a man with an innovative view and very practical, too.

Mr. Rogers?

Mr. ROGERS. Thank you.

I want to share in that comment to say that our committee, I am sure, will go into some of your suggestions to see what can be done. Thank you.

Mr. ROSTENKOWSKI. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I have a question or so. Do you believe in the arbitrary assignment of patients to physicians?

Mr. KOCH. I didn't put it quite that way, Dr. Carter. What I believe is that we have to have a system very comparable to the HIP which we have in New York where you select your doctor.

But then, you are to stay during the contract period with that doctor unless you can show there is some legitimate reason why you should not be able to get out from under that contract prior to the expiration of the contract year. You can go to somebody else, if you have some legitimate reason not to be assigned to that doctor, or that hospital. But what I am suggesting is what we already do with middle-class people under contracts. That is not to permit in a contract period this shopping around and this duplication of doctor's services.

Mr. CARTER. What is the average salary of one of the physicians you mentioned who is employed at such a hospital as you described?

Mr. KOCH. I really am not able to answer that.

Mr. CARTER. In considering that, we need to think about the salary of the physician in relation, of course, to his ability to do his job. We have to really think about it because if he is on a salary it should include enough for him to educate his children.

Mr. KOCH. Doctor, you and I have worked very closely together on so many things. Generally we think alike. I suspect on this issue we think alike, too, which is to save taxpayers' money and not permit ripoffs to take place.

Would anyone yesterday on the floor of the House have suggested that in addition to the salaries that Congressmen receive, that they also ought to have a special fund to send their children to college? People would laugh at that. Why should doctors be treated differently than a patient?

Mr. CARTER. Certainly $57,000 should be enough money to educate one's children.

Mr. KOCH. May I suggest, Doctor, one of the highest-paid professions in this country is the doctor's.

Mr. CARTER. What is the average salary of the physicians?

Mr. KOCH. I don't know the average salary, but the medical profession is one of the highest-paid.

Mr. CARTER. Let me tell you, it is $51,000 a year. Excuse me for saying this, because I have great respect for the gentleman. Actually as you know, sickness takes no holiday. The doctor is not limited to an 8-hour day.

Thank you, Mr. Chairman.

Mr. KOCH. If I may just say this, Doctor: I happen to have the highest regard for the medical profession. I don't want in any way to indicate that doctors are not doing a good job or they are not worth their salt. What I am simply saying is that if the average salary of a doctor is $51,000, remember what that means.

That means many get more. I happen to think that the salaries Members of Congress get——

Mr. CARTER. Their salaries are higher.

Mr. KOCH. All I am saying is that Members of Congress all get the same salary. It is not an average. There is no Member of Congress getting $100,000 or $200,000.

Mr. ROSTENKOWSKI. Some of us should though.

Mr. CARTER. I think you have been a wonderful witness. Thank you.

Mr. ROSTENKOWSKI. Thank you very much. As usual, you were very enlightening.

Congressman Cohen.

STATEMENT OF HON. WILLIAM S. COHEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. COHEN. Thank you, Mr. Chairman.

I hope you will overlook my enthusiasm in thinking I could be heard this morning. Even though the ranks are reduced somewhat, I am glad to see we have at least maintained the 2 to 1 majority.

I do want to thank you for the opportunity to testify before the committee, and commend both of you for holding these joint hearings.

H.R. 3 is aimed primarily at curbing the excesses of providers who unscrupulously take advantage of the poor and the elderly. The major thrusts of this legislation are the control review mechanisms set forth in the legislation which are long overdue initiatives. As a cosponsor of this legislation, I am in strong agreement with those provisions in the bill which, together with the already enacted legislation establishing an Office of the Inspector General, will permit Federal and State regulatory agencies to close loopholes and curb illegal and unethical practices in Federal health programs.

There are, however, two points related to the bill which I believe warrant comment and further examination.

First, there is a need to counterbalance punitive and after-the-fact regulatory approaches to fraud and abuse with regulatory provisions that are self-corrective. This is necessary to prevent the entry into the health market of unqualified or unscrupulous providers before they can gain control over a particular market or service. I believe the Government policies which now regulate the provision of home health services offer us some lessons which should be applied in refining H.R. 3.

In the closing months of the last Congress and again in this Congress, I introduced legislation to develop a set of standards which will insure quality care and utilization control in the home health programs of the Federal Government. Home health programs are to the homebound ill and disabled what outpatient services are to the ambulatory ill and disabled. These services are, in short, outpatient care programs brought to people who cannot travel to the so-called "shared health facilities" referred to in H.R. 3.

True, the type of care given and the providers of home health care often differ in experience, credentials, and competency from those in ambulatory care facilities. But few would dispute the necessity or desirability of high quality, cost-conscious delivery of services either in the home or the clinic. Home health services are an important element in the continuum of health care we so urgently need to give to our elderly, to our disabled, and to our poor and broken families.

Congress and the administration have been reluctant to make more home health services available without assurance that the public dollars needed for such care would be well spent. Joint hearings were held in October of 1975 by the House Select Committee on Aging's Subcommittee on Health and Long-Term Care, of which I am a member, and the Senate Special Aging Committee's Health Subcommittee.

The hearing examined regulations proposed by HEW which would have admitted proprietary and single-service home health agencies as providers under medicaid. HEW subsequently withdrew these regulations because there were no standards to assure quality care. The Department then instituted numerous public hearings and meetings between providers and consumers to address the issues raised before our subcommittees. Unfortunately, these efforts failed to produce a set of standards.

I believe the issue then is identical to the issue we are facing now. Present home health standards already in effect under medicare may be inadequate tomaintain quality care when services are made more available through participation of a greater variety of provider groups.

What is needed is a positive and comprehensive approach which can set meaningful standards for quality before we repeat our experience with medicaid providers of clinic-based ambulatory care.

My legislation, H.R. 3231, creates a Special Commission on Quality Assurance and Utilization Control in Home Health care, composed of individuals familiar with home health programs both as providers and consumers, individuals who are familiar with the processes of accreditation and certification, and State and Federal representatives who must administer programs. They woul be able to develop the most responsive set of standards consistent with our present knowledge of home health care.

At the end of 1 year, they would present these standards to the Congress and the administration for approval. If these standards are not cost effective, Congress would be in a position to disapprove the regulations and allow the administration to propose alternatives.

Unlike other commissions which seemingly never complete their tasks, the commission I propose would have only 1 year to complete its study. It would review such things as training requirements, methods of peer review, establishment of patient advocates, proficiency testing of providers, need for onsite review, certification of need, eligibility requirements, and Federal and State roles. At the end of the year, the Commission would expire.

I have been informed by knowledgeable persons in the field that such a job could be done in this limited time. The present inaction, I believe, is only a reflection of our failure to bring together people who have the knowledge and the motivation to produce such standards.

This legislation, as a forerunner to any possible legislation to expand home health services to both medicare and medicaid or title XX recipients, is an essential step in the evolution of a more uniform, more coordinated, more rational and more humane approach to the Federal financing of health care. I would hope that the members of the subcommittee would include these provisions in the medicare and medicaid antifraud and antiabuse amendments as a needed preventive measure. This approach would complement existing provisions of H.R. 3, which develop clearly stated enforceable standards and penalties for ambulatory care.

The second concern I have with the legislation deals with the provisions which amend the existing Professional Standards Review Organizations Act. The PSRO mechanism was instituted to assure the quality of care delivered by health providers. H.R. 3, in effect, diminishes that mandate by making peer review optional for providers in long-term care facilities. In my opinion, one of the consequences of this provision may be to weaken the already inadequate peer review mechanisms which Public Law 92–603 requires for chronic illness and long-term care.

A recent study conducted by my Health and Long-Term Care Subcommittee seems to show that no PSRO long-term care program surveyed had implemented the procedures specified in chapter VIII of the PSRO manual. The survey also indicated that currently operational long-term care review programs are oriented toward utilization control rather than quality assurance. This state of affairs could be used as a reason to drop PSRO's from long-term care review or it could serve as a reason to increase our efforts to improve currently operational and future PSRO programs.

At a time when there is just beginning to be an awareness of the need for active physician involvement in long-term care and geriatric medicine, deemphasizing PSRO's for institutional long-term care may be a mistake. Since there are similar review mechanisms in hospitals and clinics, removing these requirements for long-term care facilities might make the role of the physician in peer review procedures even less clear. Admissions, continued stay reviews, improved medical evaluation, patient- and problem-oriented standards for long-term care may suffer accordingly.

We know that existing review organizations have not realized their potential for improving the quality of medical and nursing care in long-term care institutions. The same can be said about the acute hospital care, and ambulatory care. However, we cannot expect that by elevating one PSRO function to the detriment of another that we will necessarily get better results—as has been proposed in effect by sections 1155(g) and 1154(b).

We must improve, on a prospective basis, review and quality control procedures for our nursing homes, no less than for our medicaid clinics, for our some health programs no less than for our hospitals. If the existing PSRO procedures are universally bureaucratic, wasteful or inappropriate, let us revise them and improve them, or replace the program with one that works. I have serious reservations about shifting emphasis without providing incentives that can lead to better and more responsive standards and quality control procedures.

Those are the two major points I would like to make today: One, the need for inclusion of my measure H.R. 3231 to deal with the entire issue of providing standards before we actually allow providers to get into the business; and second, to at least raise the question about the inappropriateness of preferring one institution over another as far as PSRO's are concerned.

Mr. ROSTENKOWSKI. Thank you very much, Congressman.

Mr. Rogers?

Mr. ROGERS. Thank you very much.

I think the points you have raised are excellent, and I am sure the committee will look at them carefully.

Mr. ROSTENKOWSKI. Dr. Carter?

Mr. CARTER. I am glad to have the distinguished gentleman from Maine with us today. I think your statement was excellent.

Mr. COHEN. Thank you.

Mr. ROSTENKOWSKI. Thank you again.

Senator Moss?

Thank you, Senator, for joining us this afternoon. Nobody recognizes more than I do the enormous contribution you made to the efforts that we are trying to display here. You have done a real tremendous service to our country and certainly to the effect of what we are going to try to incorporate in legislation.

It is nice to see you back here. I am sure that my colleague, Mr. Rogers, would like to make some comment.

Mr. ROGERS. Thank you, Mr. Chairman.

I do want to reiterate that we appreciate the remarks you made and that we are very much aware of the contribution you have made. We are most anxious to hear the suggestions you have to give us today and the testimony you will present to the committee.

Thank you for being here.

STATEMENT OF HON. FRANK E. MOSS, A FORMER U.S. SENATOR FROM THE STATE OF UTAH

Senator MOSS. Thank you very much. I am pleased and honored to have these comments. I am privileged to come here and testify today. You know of my long continuing interest in this problem.

Senator Church, who is the Chairman of the Special Committee on Aging, intended to appear but is not able to appear and asked if I could present for him his written testimony together with a report that he is releasing today from the Comptroller General, and ask that these be made part of your record.

Mr. ROSTENKOWSKI. Without objection, Senator, those will be made part of the record of this hearing.

Senator MOSS. I am honored to be permitted to appear before these two great subcommittees of the major committees of the House and to testify in favor of the important legislation that you are considering to help stem the tide of fraud and abuse in Government health care programs.

As you know, I served as chairman of the Subcommittee on Long-Term Care of the Senate's Committee on Aging and conducted some 49 hearings related to medicare and medicaid abuse. One result of this work was our 12-volume report on nursing home problems.

I would like to leave one of these reports with you as an example. The result is an in-depth look at the flow of drugs through nursing homes which we concluded is essential without controls.

On page 284 and following, you will find a detailed discussion of what we termed widespread kickbacks between nursing home operators and pharmacists.

In September of 1975, we started the first phase of an intensified investigation which concerned fraud and abuse among clinical laboratories and related fraud perpetrated by owners of medicaid mills, that is, small shared health facilities which checker the ghettos of the major cities, catering to the walk-in trade.

As many of you remember, working together with the Better Government Association, we rented a storefront in Chicago, pretending to be a group of practitioners opening for business. A sign in the window and a telephone number announced: professional inquiries invited. It wasn't long before our telephone started ringing off the hook. Twelve laboratories appeared at our storefront, and offered our investigators kickbacks ranging from 25 to 55 percent if we would agree to send all our laboratory business to that particular laboratory.

Armed with information that 12 laboratories gave kickbacks and the general amount that was offered, investigators sifted through paid billings in the Illinois comptroller's office and constructed a profile on each laboratory. We knew precisely which physicians used each of the 12 laboratories. We then selected 50 physicians for interview from this list.

The physicians which our investigators found were primarily foreign medical graduates working for foreign mills. When confronted with our information, they readily admitted receiving kickbacks from the laboratories as well as from other providers.

However, in at least half of the interviews, the foreign-trained physicians were not the recipients of the kickbacks. We learned that the illegal rebates were being paid to the businessmen who owned the medicaid mills. We were amazed to learn that many of these physicians were working essentially on commission. They were allowed to keep only 20 to 40 percent of the moneys they generated from seeing medicaid patients.

Clearly the incentive was to optimize patients — that is, to see as many patients as possible and to order as many tests as possible. In our financial analyses we found that some medicaid mills receive over $1 million from medicaid each year. Of this amount, more than 50 percent was going to various businessmen who owned or rented the real estate.

The report drafted by our committee staff called attention to these matters, adding a number of startling conclusions. For example, the report concluded that $1 out of every $5 paid for clinical laboratory services is fraudulent. It concludes that a small number of laboratories control the bulk of medicaid business.

The report concludes that, at least in the States which came under investigation, kickbacks are widespread among labs specializing in medicaid business. In fact, it appears to be necessary to give a kickback in order to secure the business of physicians or clinics who specialize in the treatment of welfare patients.

The average kickback to physicians or medical center owners in Illinois was 30 percent of the monthly total the lab received for performing tests for medicaid patients. Kickbacks took several forms including cash, furnishing supplies, business machines, care or other gratuities as well as paying part of a physician's payroll expenses. Most commonly it involved the supposed rental of a small space in a medical clinic.

The report concludes that it is apparent that the law passed by the Congress in 1972 prohibiting kickbacks and mandating a $10,000 fine and a year in jail upon conviction is not being enforced.

When I was confronted with an early draft of this report, I was shocked by the conclusions that the staff reached in their work with Chicago's Better Government Association. I decided to go to that city and see things for myself, accompanied by Senator Pete V. Domenici of New Mexico.

I saw the proliferation of so-called medical clinics spreading like mushrooms all over Chicago;

I saw their glaring signs beckoning medicaid patients to utilize health care services;

I visited a postage stamp-size clinical laboratory which billed medicaid for almost $200,000 last year. There was little in the way of equipment and no lab technicians in evidence. While the owner assured us as to the quality of the work performed, I heard from the owner himself that he chose to send his wife's sample blood for test to another laboratory.

I visited the sparkling new laboratory of Illinois Masonic Hospital and saw its sophisticated new machines, only to learn that the hospital could not obtain much medicaid lab business because of its refusal to offer kickbacks.

I interviewed a physician who received over $100,000 from medicaid last year. I asked him to check nine lab invoices presented to medicaid for payment by D. J. Clinical Laboratory of Chicago against his records. The doctor told us that he had not ordered 55 percent of the $259 total in lab tests for which D. J. had billed the Illinois medicaid program on these nine invoices.

The same doctor told us that he received a rebate of $1,000 per month from the laboratory in exchange for sending them all his medicaid business. The kickback was described as rent for a 6- by 8-foot room in the physician's office. The doctor's rent for the entire suite was $300 a month and yet he received $1,000 per month for the rental of a 6 by 8 room!

Finally, I interviewed a businessman who owns two medical clinics employing foreign-trained doctrors who received about $300,000 in medicaid payments in 1975. This man admitted sending all of his lab business to one company in Chicago. He told us he received a rebate of 50 percent of the amount medicaid paid for laboratory tests which physicians in his clinics ordered for welfare patients.

I cite these facts to you in support of the contention that fraud and abuse is rampant in the medicaid program. In my view, this is because of the bifurcated nature of the medicaid program. Both the States and the Federal Government are looking to each other to prevent fraud and abuse. Technically, the States are responsible; at least that is my reading of title XIX.

In order to document this problem further, we decided to an in-depth look at the operation of the medicaid program in the State of New York. In addition to the normal investigative techniques we decided to have investigators pose as medicaid patients entering shared health facilities for treatment.

Our staff also posed as businessmen who answered ads in the New York Times where every Sunday the display of medicaid mills for sale continues. Our findings are contained in the report, "Fraud and Abuse Among Practitioners Participating in the Medicaid Program," which I provide to this committee for its use. We learned a great deal from this experience.

For example: The provider abuse and surveillance activities in the city and State of New York are in a shambles. Despite the fact that Federal funds have been made available at the rate of 90 percent for development and 75 percent of the operating costs of automated data systems, the management systems at the State and county level have not been modified since the start of the medicaid program 10 years ago.

New York City, despite an impressive computer capability, does not have such rudimentary fraud detection aids as provider, vendor, and recipient profiles. All of its files beyond the past 3 months are stored in pasteboard boxes in a warehouse in Ryerson Street in Brooklyn. Efforts to prosecute cases have been hampered by the inability to retrieve the original invoices submitted by providers which are in these cardboard boxes, often broken open and scattered about.

One city employee on the scene told us that if we can recover 50 percent of the invoices we want, we're lucky.

As an example of what happened when perfectly healthy Senate investigators entered medicaid mills posing as derelicts, I offer the following:

One. Private Roberts entered Gouveneur Medical Center in the lower East Side of Manhattan, New York City, complaining of burning and discharge in his urinary tract. He was given a general physical and a tuberculosis—TB—test, told he had a heart murmur and given an electrocardiogram—EKG. A second shopper, Investigator William Halamandaris, entered the same clinic several minutes later complaining of a possible head cold. His head cold was diagnosed as sinusitis. He was given a general physical, an EKG, a TB test, told he had a severe heart murmur and that he probably had rheumatic fever as a child. In addition, the doctor ordered a series of X-rays of the patient's sinuses and chest, and referred him to the heart specialist—all in the space of 3 minutes.

Third shopper, Patricia G. Oriol, chief clerk of the Senate Committee on Aging, entered this same clinic a month later complaining of a possible cold. She too was told she had a severe heart murmur and high blood pressure and told to return for further tests.

All three shoppers were given a large amount of medication and specifically instructed to have the prescriptions filled at the pharmacy next door. It is a violation of New York State law to recommend a specific pharmacy.

Two. At the Riis-Wald Medical Center, one block away from the Avenue C Clinic on the lower East Side, Private McDew was given a general physical, referred to the chiropractor and the podiatrist. The podiatrist informed Private McDew that he had hammer toe, and flat feet—for which the podiatrist placed arches—actually they were small pieces of sponge in his tennis shoes. He was also told his feet sweat. Subsequently, the same shopper met the same podiatrist—again on referral as a result of a ping-pong—in a second clinic in uptown Harlem. The podiatrist, after putting face and name together, checked his notebook and informed our investigator: Remember what you had before? Well, you've got it again. He placed another set of arch supports—this time in the investigator's oxfords. In addition to arch supports, Private McDew received skull and chest X-rays more than 10—and was ordered to return next week for additional tests. When Private Roberts entered the Riis-Wald Clinic, he received a general physical and was referred to the podiatrist, but had to refuse treatment because his toes had been painted the previous day by another podiatrist.

I have other examples. I will not read them.

As you know, Mr. Chairman, I too, posed as a medicaid patient and sought treatment at the East Harlem Medical Center and two other mills in New York. From that experience I formed some impressions as to what it is like to be a medicaid patient. At our recent hearings I stated:

> If you are a medicaid patient, you can expect to be treated in a clinic located in a dilapidated part of the city.
>
> The outside of these clinics, or medicaid mills, are garish. Most offer a brick facade. They may be brightly painted, with awnings, banners and pennants attracting the eye. The front window lists an impressive array of services—everything from a psychiatrist to a podiatrist.
>
> Inside, it will be cramped and sparsely furnished. It will be dirty. Cleanliness is not prized in medicaid mills; it costs too much money. The floors look like they haven't been swept in a month and the restrooms are abominable.
>
> As you enter a mill you will be greeted by a receptionist or someone who looks like a nurse. This is important because you never know for sure. This receptionist will ask for your medicaid care. She will xerox it a number of times. You may be asked who you want to see or what your medical problem is or you may not.
>
> Now you wait for an hour, sometimes two. While you wait the receptionist or someone else may suggest that you should see Dr. So-and-so, the chiropractor, or Dr. XYZ, the podiatrist.
>
> When you do get to see a practitioner, your visit will be brief—usually from 3 to 5 minutes—and the examining room will be tiny.
>
> You will be given a general examination no matter how specific your complaint. If blood pressure is taken or a stethoscope is used, the odds are it will be done through your clothing. It is likely that you will not be touched. Medicaid doctors don't like touching their patients.
>
> At some point the doctor will take blood. The taking of blood confirms that treatment has been rendered to the patient, but, perhaps just as important, samples presented to clinical laboratories will generate a return of $15 each from the laboratory.
>
> In addition, you are going to be asked for a urine sample; you will be given a number of X-rays and perhaps a shot or two. You can count on receiving several prescriptions. In most cases you will be directed to a particular pharmacy to have your prescriptions filled.
>
> If you're not sick, you won't be told you're not sick. If you are sick, the odds are you won't be helped. In the last analysis, the best description is the one given to us by a mill owner who said "Medicaid isn't medicine, it's business. Curing patients is good medicine but bad business.

From our experience posing as businessmen from Chicago trying to buy into the medicaid mill business we gathered totally incredible information. Mill owners told us "how to maximize our patient revenues," how to cheat and not get caught, and that protection against the enforcement of existing standards could be purchased by payoffs to appropriate health officials.

Accompanied by a physician we sometimes got down to dickering on the price we would pay. One owner wanted to make us a package deal and throw in some of his "medicare mills" in Miami. Still other owners spoke of the involvement of organized crime in the business.

They spoke of using arson as a means of disposing of an unprofitable mill—collecting the fire insurance. They spoke of some union officials who allegedly are running a protection racket charging a founder's fee for allowing a mill to be located in a particular area.

All of these facts were turned over to the U.S. attorney for the Southern District of New York with whom we were working closely. His investigations continue.

From my first-hand personal experience I want to tell you that I am outraged. I am angry that money the Congress has appropriated for care of the aged, blind, and disabled is going to line the pockets of a few businessmen and real estate operators who own shared health facilities in the ghettos of our large cities.

I am angry that more than 10 years after the enactment of the medicaid program we find the resurrection of that abhorrent dual track of medical care which provides one standard of care for the rich or comfortable and another for the poor.

I am angry that so much of the taxpayers' hard-earned dollars are lost to fraud and abuse. Our citizens work too hard for their money to be able to stomach the fraud and abuse which by now must be evident to anyone who subjects the medicaid program to even the slightest scrutiny.

If I were to estimate how much fraud there is in medicaid, I would guess about 10 percent or $1.7 billion. This is just an educated guess. Many people who have worked in this field tell me it is more like 20 percent. However, I suggest the size of the theft is not the problem. There is abundant evidence that medicaid is not working. Our inability to manage this program casts a cloud over our ability to manage a 10-times-larger national health insurance.

By way of solutions, I endorse the fraud and abuse bill you are considering. This will help in the short run. In addition to creating an Office of Inspector General in HEW, which the Congress accepted last year, I have suggested creating a new Division of Health and Welfare Fraud within the Department of Justice to prosecute fraud in government health care programs. The reason for this idea is that we learned that thousands of dollars were being lost to the Federal Treasury every day because of the running of the statute of limitations; by the same token, numerous lawbreakers escaped punishment as medicare and medicaid cases languished on the desks of our U.S. attorneys.

By way of longrun solutions, I think you should take a hard look at the way we finance government health care programs. I am confident that the members of the two committees represented here today will be able to fashion appropriate solutions.

Thank you for inviting me to be here.

[Senator Church's statement and the report by the Comptroller General follow:]

STATEMENT OF HON. FRANK CHURCH, CHAIRMAN, U.S. SENATE SPECIAL COMMITTEE ON AGING

Mr. Chairman and members, it is good to be here today as you consider solutions to widescale fraud and abuse in government health care programs. Thank you for inviting my testimony, and for the generous references in your staff report to the work of the Senate Special Committee on Aging.

On behalf of that Committee, I would like to share briefly with you some of the evidence we have derived from several reports, field work, and more than 50 hearings over the past seven years relating to one or more aspects of the Medicare and Medicaid program which we have conducted in the past 7 years.

NURSING HOMES

Senator Frank E. Moss, recent Chairman of our Subcommittee on Long-Term Care, the Committee has released a series of reports on nursing home problems. Among the abuses discussed were:

Kickbacks between pharmacists, other vendors and nursing homes.

Listing wives or other family members on the payroll when no work was performed.

Making donations to political parties and charging them to Medicaid.

Contracting with wholly owned subsidiaries and pretending that the high cost passed on to Medicare could be justified as an "arms length" transaction.

Charging excessive legal fees or excessive travel and entertainment expenses to Medicaid.

Withholding the $25 a month personal spending allowance guaranteed to Medicaid patients. In this connection, all 30 nursing homes surveyed by the General Accounting Office in its 5-State Sample were found to have serious shortcomings in the protection of patients' funds. This audit, which we released nearly a year ago, has called upon HEW to issue new regulations to protect the integrity of patients' funds. To my knowledge, the Ford Administration had not done so before it left office.

At this point, I would like to release our latest GAO report. We had asked GAO to evaluate the types of inflated or unallowable costs being most often identified by audits, and the adequacy of HEW and State system controls to detect such costs.

The audit, which I am making public today, concerned the States of New York, Massachusetts, Florida and Virginia. GAO states that the most prevalent unallowable costs involved:

Nursing homes "failing to offset certain costs with related income." For example, a county-owned nursing home in New York failed to report $166,000 in income from Medicare for in-house physician services to Medicaid patients but claimed the full cost of physicians' salaries as a reimbursable Medicaid expense. Similarly, a Florida nursing home admitted contributions of $26,700 made by families and friends on behalf of specific patients. No adjustment was made to the Medicaid cost report by the facility for these contributions.

Cost unrelated to patient care. At one for-profit nursing home in Florida State auditors detected $79,000 in such charges, or 19 percent of the total costs claimed. Among the items disallowed were $32,700 in owner's compensation, because it was in excess of the Medicare guidelines; $26,600 in income from the sale of Medical supplies that should have been offset against medical supply expense of the home; $6,100 of interest, because it was paid to stockholders; $6,700 for a Cadillac automobile and boat expenses and depreciaiton not related to patient care; $3,000 in equipment rental income which should have been offset against related income; $1,600 income on drugs which exceeded expenses; $1,600 in consultant and director's fees and $3,700 for other items such as personal travel and entertainment expenses, telephone expenses related to an officer's home phone, auto tires not related to patient care and income from incidental oxygen sales not offset against expenses.

Unsupported or "paper" costs. In Massachusetts, a city-owned nursing home claimed as a reimbursable cost a "paper" property tax bill from the city for $123,000, which was not actually paid. In all, auditors disallowed $223,000, or 20 percent of $1.1 million in costs submitted by this municipal nursing home.

GAO concluded that field audits (as distinguished from desk audits) were highly productive regardless of whether the facility was private nonprofit, for-profit, or a public facility. GAO noted that Massachusetts and New York were having difficulty collecting overpayments and that Florida had taken no action to identify or collect overpayments. Only Virginia had adopted procedures to facilitate systematic identification and recovery of overpayment. Consequently, GAO calls upon HEW to assess periodically the States' efforts to identify overpayments and to deny Federal financial participation when States do not establish effective recovery programs on a timely basis.

HOSPITALS

Over the years the Committee on Aging has paid relatively little attention to hospitals. We believe that most are reputable and offer good care. However, there is a new kind of hospital springing up in the ghettos of our major cities, and we believe they require scrutiny.

At our hearings in September 1975, one investigator testified about unnecessary surgery being performed at one Chicago hospital. Employed as a janitor, he learned that one doctor performed more tonsillectomies in a day than six doctors performed in a week at Chicago's busiest ear, nose, and throat clinic. The victims included a family of six youngsters who had this surgery on the same day with little evidence of medical necessity. The investigator, clad in his janitorial overalls, was requested to help move patients in the operating room and was assigned the task of monitoring patients after surgery.

A second investigator testified he took a room in a skid row hotel to test the theory that it served as a recruiting point for an unscrupulous ambulance company and a second Chicago welfare hospital. He found the story true. Upon finding that the investigator (an apparent drunk) had a Medicaid card, the flop house operator gave him a jug of wine and arranged an ambulance ride to the hospital on the other side of the city. The ride cost the taxpayers $45 for the pickup and $1.35 a mile thereafter. While at the hospital the falsely alcoholic investigator received little attention; however, the hospital records suggested medical complications and treatments for which the hospital was reimbursed.

I would make it clear that these two examples are not cause to indict all or large numbers of America's hospitals, by any means. I simply suggest that we need to examine closely the billings of some hospitals which trade largely in Medicaid patients. I would emphasize that hospitals receive 31 percent of Medicaid funds but account for less than 3 percent of the Medicaid audits conducted by the HEW audit agency in the last 5 years.

CLINICAL LABORATORIES

You probably are familiar with our recent investigation and report about fraud and abuse among clinical laboratories. In our 5-state study we concluded that $45 million out of the $213 million in Medicare and Medicaid payments for laboratory services is either fraudulent or unnecessary. We found the average kickback in Illinois between laboratories and owners of shared health facilities was 30 percent of the total which Medicaid paid to laboratories for tests performed for Medicaid patients.

We concluded: "In practical terms, this all means that any laboratory so inclined can bill Medicaid for a patient a doctor has never seen for blood never drawn, for tests never performed, at a rate exceeding four times cost and twice the prevailing charge for private paying patients with nearly absolute assurance that they will not be caught and prosecuted."

As a postcript, a followup field examination and a more recent letter from an informed source indicates that these practices are continuing in California. In Illinois, however, U.S. Attorney Sam Skinner has indicted 6 of the laboratories which we investigated initially. In New York, fee schedules for laboratories have been reduced 30 percent, and Assistant U.S. Attorney George Wilson has also obtained half a dozen indictments against laboratories.

PHARMACIES

In addition to being unwilling participants in kickback schemes, pharmacists are involved in other schemes which may be as widespread. In September 1975, the Michigan Post Payments Surveillance Unit testified that the most frequent pharmacy abuses they encountered include:

Billing for nonexistent prescriptions.

Supplying generic drugs and charging for brand names.

Dispensing less than the prescribed amount of medication and charging for the full amount.

"Fee splitting," or charging for two 15-day supplies instead of one 30-day supply of drugs.

These same kinds of abuses were encountered in our recent investigation of shared health facilities or "Medicaid mills."

PRACTITIONER ABUSE: MEDICAID MILLS

Last August we revealed our in-depth investigation of shared health facilities or Medicaid mills located in urban ghettos. These facilities thrive on great numbers of patients. The more patients the more money. In a typical facility, all medical disciplines are represented, from psychiatry to podiatry. The owner is generally a businessman who rents or has title to the building. He hires practitioners (usually foreign trained) and pays them on a commission basis. He allows them to keep only 30 to 50 percent of the income they generate from Medicaid. Practitioners are pushed to see more and more patients in less and less time, to order unnecessary tests and to "share" patients with other practitioners without regard to medical necessity. As a result of these factors and the slow Medicaid payment, it is not surprising that reputable physicians and dentists avoid Medicaid practice and that the quality of care offered in shared health facilities leaves much to be desired.

FACTORING COMPANIES

Physicians and other providers who have large outstanding accounts receivable cannot afford to wait four or five months to be paid by Medicaid. Consequently, in states with slow payment, providers may deal with a factoring company which offers cash in exchange for the accounts receivable. Factoring firms take a cut of from 12 to 25 percent for their trouble in collecting the money.

The Better Government Association of Chicago and the Chicago Tribune have asserted that organized crime is muscling into the factoring business. In testimony before our Committee the BGA reported investigating 3,569 physician bills submitted to factors, of which some 1,711 had allegedly been raised to higher amounts by factoring firms. Factoring firms dispute both charges. For my part, I would like to strongly protest the delays in Medicaid reimbursement to providers in some States. This is the root of the factoring problem. It is also a significant disincentive to attracting honest hardworking practitioners to our ghetto areas. To my way of thinking, delays in payments of three, four, or five months are inexcusable.

HOME HEALTH AGENCIES

As a strong advocate of the need to expand home health benefits as an alternative to institutionalization, I emphatically believe that ways must be found to protect the fiscal integrity of home health programs under Titles XVIII, XIX, and XX of the Social Security Act. A particular problem may be presented by Title XX which is essentially a block grant program with 75 percent Federal funding to help the States establish social service programs for indigents. There are few controls evident in this program. As you know, Mr. Chairman, we plan to pursue this and related issues in hearings on March 8.

RECOMMENDATIONS

Mr. Chairman, I am convinced that—despite the important investigations of several Committees of the Congress—we still do not understand very much about fraud and abuse, and, I am sure, even less about how to correct the problem. Like the little boy with a fishing pole bent double, we don't know exactly what we have caught, but whatever it is, it is a big one.

I heartily endorse the provisions of the bill you are addressing here today, but I want to echo the caution of Chairman Rostenkowski. He reminded his colleagues at the time of introduction that the passage of this bill is only a small, albeit badly needed, first step. I think that it is vital that we continue our investigations and hearings in an effort to learn precisely what is wrong with Medicare and Medicaid. One area which should receive our attention is our method of reimbursing providers. It seems to me that payment, the amount, method of computation, and controls to assure that quality services are delivered are the crucial questions with which we must grapple.

In the short run, there are a number of things we can do. The Fraud and Abuse bill pending here today embraces many of them. I particularly favor making fraud a felony instead of a misdemeanor under Medicare and Medicaid.

I think we should do everything possible to help the States establish offices similar to that of Mr. Charles J. Hynes, Special Prosecutor for Nursing Homes and Assistant Attorney General, State of New York, who testified here this morning.

It is my feeling that Federal financing to help the States to hire auditors and investigators would be of immense assistance. In the audit I released today, GAO points out the importance of field audits. Mr. Hynes has been able to identify $2,500 in inappropriate payments for every day an auditor is on the job. As for the utility of trained investigators, the Michigan "Fraud Squad" to which I referred, with respect to pharmacists, reports recoveries of $6 for every $1 spent in investigative salaries.

What I am suggesting is that we consider furnishing Federal funding for a period of three years to help the States establish enforcement units, and hire the investigators and the auditors they need. Thereafter, the Federal funding for personnel might be phased out, with the States keeping the money recovered as a result of successful enforcement actions. This approach, I should think, would offer the States a strong financial incentive to protect the integrity of the Medicaid program.

I plan to introduce such a measure in the Senate. I offer it to you in principle for your consideration.

REPORT TO THE SUBCOMMITTEE
ON LONG-TERM CARE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

UNITED STATES GENERAL ACCOUNTING OFFICE

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

State Audits To Identify Medicaid Overpayments To Nursing Homes

Social and Rehabilitation Service
Department of Health, Education, and Welfare

This report identifies the most prevalent types of excessive costs which have been identified and disallowed in audits of skilled nursing facilities in four States. It discusses HEW's efforts to implement section 249 of Public Law 92-603, which requires the States, beginning July 1, 1976, to reimburse nursing homes on a cost-related basis. Some States need to increase their audit effort to meet existing requirements and increase their efforts to recover overpayments identified in audits.

HRD-77-29

JAN. 24, 1977

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

The Honorable Frank Church
Chairman, Subcommittee on Long-Term Care
Special Committee on Aging
United States Senate

Dear Mr. Chairman:

This report is in response to the Subcommittee's request for information about the methods and techniques used by nursing homes to inflate Medicaid costs and reimbursements.

This information is based on analysis of the costs disallowed in 340 desk and field audits made by the States of New York, Massachusetts, Florida, and Virginia and in our audits of 12 skilled nursing facilities in the four States.

The report also addresses the Department of Health, Education, and Welfare's actions to implement section 249 of Public Law 92-603, which requires States, beginning July 1, 1976, to reimburse skilled and intermediate nursing facilities on a cost-related basis.

Our review was made pursuant to the Subcommittee's request of December 19, 1974. As requested, we have not provided HEW, the States, or the selected nursing facilities an opportunity to review and formally comment on our report. However, we have discussed our findings with HEW representatives and communicated our findings to the States and facilities involved.

This report contains recommendations to the Secretary of HEW. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on the actions taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. We will be in touch with your office in the near future to arrange for release of the report so that the requirements of section 236 can be set in motion.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

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ABBREVIATIONS

CPA	Certified Public Accountant
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
ICF	intermediate care facility
SNF	skilled nursing facility
SRS	Social and Rehabilitation Service

COMPTROLLER GENERAL'S
REPORT TO THE SUBCOMMITTEE
ON LONG-TERM CARE
SENATE SPECIAL COMMITTEE
ON AGING

STATE AUDITS TO IDENTIFY MEDICAID
OVERPAYMENTS TO NURSING HOMES
Social and Rehabilitation Service
Department of Health, Education,
and Welfare

DIGEST

Nursing homes submit reports of their costs for each year to agencies of their respective States. These reports are used to determine how much these homes will be reimbursed by Medicaid. The objectives of this review were to obtain information on

--the types of inflated or unallowable costs being identified by audits,

--the adequacy of HEW and State systems and controls to detect such costs, and

--the progress being made by HEW in implementing section 249 of Public Law 92-603, requiring that payments under Medicaid for nursing home services be made on a reasonable cost-related basis effective July 1, 1976.

UNALLOWED COSTS IDENTIFIED

The most prevalent unallowable costs identified by State and GAO audits involved:

--Nursing homes failing to offset certain costs with related income. For example, a county-owned nursing home in New York failed to report $166,000 in income from Medicare for in-house physician services to Medicaid patients but claimed the full cost of the physicians' salaries as a reimbursable Medicaid expense. (See p. 15.)

--Costs not related to patient care. At one profit-making nursing home in Florida, for example, State auditors disallowed costs for luxury automobiles and travel expenses. (See p. 17.)

- Unsupported or "paper" costs. In Massachusetts, a city-owned nursing home claimed as a reimbursable cost a "paper" property tax bill from the city for $123,000 which was not actually paid. (See p. 13.)

Of more than $300 million in total costs submitted by nursing homes, the States did not allow about 3 percent or almost $9 million. An additional 2.4 percent of costs claimed by nursing homes, or approximately $7 million, were not allowed because of State maximum payment limits, or ceilings. On the other hand, State audits uncovered allowable costs of over $2 million which had been understated by the nursing homes. (See p. 4.)

In addition, GAO performed field audits involving about $35 million in claimed costs and identified $0.4 million in costs erroneously claimed and $0.4 million in reported costs exceeding the applicable State ceilings for nursing home reimbursement. GAO's findings of erroneous costs were in addition to findings in State audits for those same nursing homes. (See p. 4.)

MEASURES TO IDENTIFY AND RECOVER OVERPAYMENTS

Field audits were productive in identifying costs that were claimed by nursing homes but should be disallowed. Field audits were productive regardless of whether the home was private nonprofit, profit-making, or public. At the time of GAO's visits in mid-1975 the States varied substantially in their field audit efforts.

- Florida had not issued any field audit reports on nursing homes since the State Medicaid program began in January 1970. By May 1976, Florida had issued audit reports on 23 of the State's 261 nursing homes. (See p. 23.)

--Massachusetts' policy was to field audit all nursing homes each year, but the State had a 2-year backlog. (See p. 24.)

--New York had completed field audits of only 98 of 540 skilled nursing facilities since the State Medicaid program began in May 1966. The State limited its field audits to for-profit skilled nursing homes. (See p. 24.)

In addition, law enforcement officials in Massachusetts and New York had used field audits to get several convictions of nursing home operators for fraudulently claiming costs to the Medicaid program. (See pp. 24 and 25.)

On July 1, 1976, HEW issued regulations requiring all States to field audit all nursing homes over a 3-year period unless the State already has an acceptable field audit program. (See p. 23.)

The cost of State field audits will be justified if the States can prevent overpayments and recoup overpayments identified. Only Virginia appeared to have an effective program for recovering overpayments. (See p. 28.)

Massachusetts and New York had $13.6 million in overpayments outstanding and problems in recovering it. (See pp. 26 and 28.) Florida had no recoupment program, had never recovered any payment from a nursing home for any reason, yet claimed it could recoup overpayments. (See p. 26.)

HEW should direct its Social and Rehabilitation Service to

--assess periodically whether each State identifies and reports promptly overpayments to nursing homes, as required, and

--deny Federal participation in overpayments when States do not establish an effective recoupment program promptly.

IMPLEMENTING THE LAW

Although Public Law 92-603 was enacted on October 30, 1972, HEW did not issue final regulations until July 1, 1976, and permits States to delay full implementation until as late as January 1, 1978. (See p. 30.)

The implementation of section 249 undoubtedly will cause some States and the Federal Government to spend more money on nursing home services. However, the regulations contain features--such as authorizing reimbursement limitations and requiring field audits--that could enable the States to reduce the financial burden of changing reimbursement systems.

CHAPTER 1

INTRODUCTION

On December 19, 1974, the Chairman, Subcommittee on Long-Term Care, Senate Special Committee on Aging, asked us to identify techniques used by nursing home operators in New York to inflate Medicaid costs and reimbursements. He was joined in this request by 14 New York Representatives and four Representatives-elect. The Subcommittee later agreed that we should expand our review to include the States of Florida, Massachusetts, and Virginia.

THE MEDICAID PROGRAM

Medicaid--authorized by title XIX of the Social Security Act, as amended--is a grant-in-aid program under which the Federal Government pays part of the costs incurred by States in providing medical services to persons unable to pay for such care. The Federal Government pays from 50 to 78 percent of the costs incurred by States in providing medical services under the Medicaid program. The Social Security Act requires that State Medicaid programs provide skilled nursing home services. About 7,100 skilled nursing facilities (SNFs) participate in the Medicaid program, and about 4,000 of the SNFs also participate in Medicare. 1/ In fiscal year 1976 the Federal share of Medicaid payments to SNFs was estimated at $1.5 billion, 20.3 percent of the total estimated Federal share of Medicaid payments to all providers of services.

At the Federal level the Medicaid program is administered by the Social and Rehabilitation Service (SRS), within the Department of Health, Education, and Welfare (HEW). States have primary responsibility for initiating and administering their Medicaid programs.

1/Medicare, authorized by title XVIII of the Social Security Act, is the Federal health insurance program for the aged and disabled. Part A of Medicare provides hospital insurance and also covers certain post-hospital care in SNFs or in a patient's home.

Basis for reimbursing SNFs under Medicaid

Until July 1976, Federal regulations (45 CFR 250.30 (b)(3)(ii)) stated that payment under Medicaid for SNF services shall be "customary charges which are reasonable." These regulations also stated that the Medicaid payment rate should not exceed the Medicare payment rate. The two general methods of establishing reimbursement rates were on a cost-related or fixed-fee basis. When rates were on a cost-related basis, the regulations provided for "appropriate audits."

Section 249 of Public Law 92-603, enacted October 30, 1972, requires that effective July 1, 1976, SNFs in all States be reimbursed on a cost-related basis.

Types of audits of SNF costs

Depending on the State reimbursement system, the SNFs submitted their actual costs, generally for a previous year, to the State agency or its fiscal agent. These submissions were generally referred to as cost reports and were used to determine the amount of reimbursement.

State audits or reviews of cost reports consist of either desk audits or field audits. Desk audits consist of an examination of the cost reports and any related documents at the State's office or that of its fiscal agent. In such an examination, the reviewer looks for obvious mathematical errors or other discrepancies, compares the costs submitted with previous years' costs, checks the costs reported against any State ceilings or limitations, and attempts to identify and eliminate any obvious unallowable or excessive costs. Unresolved questions may be answered by telephone. On the other hand, field audits--which may be in addition to the desk audit--consist of visits to the SNF and include examinations in varying detail of the institution's accounting records and supporting documents such as payrolls and invoices.

SCOPE OF REVIEW

The objectives of our review were to obtain information on

--the types of inflated or unallowable costs being identified by audits,

- --the adequacy of HEW and State systems and controls to detect such costs, and
- --the progress being made by HEW in implementing section 249 of Public Law 92-603.

Our review included work at HEW headquarters in Washington, D.C., and HEW regional offices in Atlanta, Boston, Philadelphia, and New York. We visited State agencies in Florida, Massachusetts, New York, and Virginia, where we reviewed and analyzed selected reports of desk and/or field audits of SNF cost reports.

In analyzing the various State desk and field audits, we did not attempt to evaluate the reasonableness of any particular disallowance except to note inconsistencies. We visited a total of 12 SNFs in these four States, and at each facility we audited selected costs reported on the latest Medicaid cost report submitted to the State for reimbursement purposes. These SNFs included proprietary, private nonprofit, and public facilities.

CHAPTER 2

IMPACT OF STATE AUDITS AND CEILINGS IN CONTROLLING NURSING HOME COSTS

In the four States we reviewed, the methods for identifying and disallowing inflated costs claimed by skilled nursing facilities consisted of (1) desk and/or field audits of cost reports and (2) limitations or ceilings on total reimbursable costs or on specific categories of expense. In the 340 State desk and field audits we analyzed, the States disallowed about $9 million as erroneously claimed, about 3 percent of the $305 million in total costs submitted by SNFs for reimbursement by Medicaid.

An additional $7.3 million in costs, about 2.4 percent of the costs claimed or submitted by SNFs, were not allowed because of the application of the States' ceilings. The State audits also increased the costs allowable to SNFs by about $2.3 million primarily through identifying understated costs during the State field audits.

For the 12 SNF cost reports we reviewed involving submitted costs of about $35 million, we identified an additional $385,000 in erroneously claimed costs that should have been disallowed by the State and an additional $379,000 which was or should have been disallowed because the costs exceeded the applicable ceilings. Some of these 12 SNF cost reports had not been field audited by the State prior to our review, but all had been desk audited. Our findings of erroneously claimed costs do not duplicate findings from any other audit. A State-by-State summary of these various audits is included as appendix I of this report.

The most prevalent types of disallowances identified by State audits and our audits involved

--the failure of SNFs to offset certain costs with related income, such as interest expense not offset by interest income;

—costs not related to patient care, such as personal expenses of SNF operators and public relations and advertising expenses; and

--unsupported or "paper" costs primarily involving "non-arm's-length" transactions between entities related by ownership or control.

STATE SYSTEMS FOR LIMITING PAYMENTS OF COSTS TO SNFs AND IDENTIFYING UNALLOWABLE COSTS

The methods used by the four States to limit costs reimbursed to SNFs ranged from a rather elaborate system used by New York, including ceilings on individual items such as administrative salaries and property expenses, to a modified version of the traditional Medicare reimbursement system used by Virginia, which paid SNFs on the basis of estimated costs and later made retrospective cost determinations through desk or field audits in accordance with the Medicare reimbursement principles 1/ subject to an overall maximum daily reimbursement rate.

Florida

As of January 1975, there were 254 SNFs participating in the Florida Medicaid program. The upper limit of reimbursement that any SNF could receive under the Florida program is the lowest of three rates: a predetermined maximum fixed rate established by State law, the reasonable patient care cost for each SNF, or usual and customary charges to the public. The State maximum rate for fiscal year 1975 was $550 per patient per month. Approximately two-thirds of Florida's SNFs received the State maximum rate in January 1975.

Each SNF was required to submit a cost report for the most recent fiscal year. Total allowable costs were to be consistent with the principles of reimbursement as established for Medicare. As of January 1975, Florida SNFs reported average monthly costs per patient ranging from a low of $453 to a high of $848.

1/Medicare reimbursement principles consist of essentially three features. First are the rules pertaining to the allowability of specific costs. Second are the procedures for cost finding, which is the process of allocating overhead costs among the routine and ancillary care activities of an institution. And third are the rules for cost apportionment, which is the process of dividing the routine and ancillary costs between Medicare and non-Medicare patients. States are free to adopt some or all of the Medicare principles for their Medicaid reimbursement systems for SNFs.

In the Florida rate-setting process, the State Medicaid agency received the cost reports from the SNFs, made desk audits of the costs submitted, and, after making any corrections, adjusted the monthly per-patient cost upward by 9 percent to arrive at the reasonable cost of patient care. Under the Florida system, these rates were prospective and were not subject to retrospective adjustment on the basis of actual experience. According to a Florida official, the reason for the 9-percent adjustment was that Florida law requires that payment for obligations incurred in a fiscal year must be made not later than 6 months after the close of that year. Since it would be difficult to make retroactive adjustments that promptly, the 9-percent adjustment was given instead of any retroactive adjustment.

SNFs in Florida were not routinely subject to a field audit. However, they could be audited at the discretion of the State Medicaid agency. We examined State desk audits and field audits which identified approximately $4.2 million of erroneous costs or costs over ceilings reported by the SNFs. The field audits covered fiscal years 1972 and 1973, while the 25 desk audits generally covered cost reports submitted by SNFs for fiscal year 1974. The 25 desk-audited cost reports showed total operating expenses of $18.3 million, and the State disallowed $2.8 million, about 15 percent for 23 nursing homes with over 90 percent disallowed as over State ceilings.

As previously stated, Florida did not routinely make field audits of SNFs, and the State, at the time of our visit, had issued no audit reports on SNF costs since the inception of its Medicaid program in January 1970. However, as of August 1975, the State had in various stages of completion 23 field audits of nursing facilities. We analyzed the results of 10 of these audits. The State auditors had identified about $1.4 million in unallowable costs or costs over ceilings, which was about 19 percent of the $7.3 million in total costs submitted by the SNFs.

Because of the State ceilings, however, the unallowable expenses directly affected the payment rates for only 5 of the 10 SNFs. The daily payment rates after audit were excessive by amounts ranging from $1.30 to $4.74 and resulted in estimated overpayments of about $682,000 which, at the time of our field visit, had not been recovered.

We visited three Florida SNFs to review the costs they submitted for 1974. All three had been desk audited but not field audited by the State. Our field review showed that the three SNFs had overstated their costs by about $363,000, 13 percent of their total reported costs of $2.8 million. One of the facilities had submitted costs we considered excessive by about $34,200, such as:

--$18,600 of proprietor's compensation costs above the State's ceilings. For the 12-month period ended November 30, 1974, owner's compensation totaled $36,000. On the basis of a schedule of allowable owner's compensation supplied to us by the State Medicaid agency, we believe the total compensation should have been $17,400.

--$8,000 of income not offset against expenses, including discounts on milk purchases, income from vending machines, pay telephones, patient laundry services, sales of drugs, and private contributions to the care of specific patients.

--$800 for expenses applicable to another SNF.

--$3,500 for unsupported costs including travel, long distance telephone calls, and promotion expenses.

--$3,300 for yellow pages advertising, overstatement of interest expense, and miscellaneous expenses.

A second SNF which we audited submitted excessive costs of $24,600 because of excess proprietor's compensation costs ($17,400); income from such sources as pay telephone, patient laundry services, and discounts on milk purchases not being offset against expenses ($6,400); and other expenses ($800). The third SNF had overstated its costs by about $303,000 but was not excessively reimbursed because its reported costs were far above the State's upper limit for reimbursement; it thus was paid the lower maximum monthly rate. (See pp. 18 to 20.)

Massachusetts

As of March 1975, Massachusetts had 237 SNFs participating in the Medicaid program. In Massachusetts SNFs were paid under a retrospective cost reimbursement system under which interim rates based on estimated costs were subject to adjustment after a State field audit of each SNF's actual costs.

The interim rate was established midway through the year in which the rate applied, on the basis of costs incurred two years before. For example, the 1975 interim rates were established using regulations issued in June 1975 and were based on 1973 costs with an inflation factor of 10 percent added to the variable costs (net operating costs exclusive of interest and depreciation).

The State made desk audits of the reports submitted by the SNFs and adjusted the costs to the extent required by the State's applicable regulations. These adjustments include State limitations on administrative and nursing salary expenses. The adjusted total cost was then divided by each SNF's total number of patient days and an inflation factor added to arrive at the interim rate for the current year. In addition, Massachusetts limited payment for total allowable variable operating costs to 110 percent of the "weighted average cost" of all facilities in the State providing the same level of care.

Until the interim rate had been established, SNFs were reimbursed at the previous year's interim daily rate. If the new rate was higher than the previous year's interim rate, the State paid the SNF the difference between the two interim rates for those patient days incurred between January 1 and the date the new interim rate went into effect. Until April 1976, however, if the new interim rate was lower, the State had no procedures to recover the overpayment other than applying the overpayment to outstanding underpayments. (See pp. 26 to 28.)

The final reimbursement amount was generally determined at least a year or more after the year to which it applied. This determination was based on State field audits of the financial records maintained by the SNFs, using regulations which the State issued annually.

As of August 1975, Massachusetts had made field audits of the actual costs incurred by a number of SNFs for calendar year 1973. We reviewed the adjustments made to the costs reported by 26 SNFs for which final rates had been established and noted that the State had not allowed $3.9 million, about 20 percent of the costs submitted, and had identified about $1.1 million of understated costs. Examples of such disallowed costs are on page 13.

We field audited adjusted cost reports for three additional SNFs that had been previously audited by the State and identified additional overstated costs of $41,000 for two of these SNFs. This amount included $18,600 for a nun's donated services which was included in nursing salaries. The nun told us she was the SNF's assistant administrator in 1973. A State official told us the nun's salary should have been included in the administration and policy planning category of expenses. If this had been done, the value of her donated services would have been disallowed because the SNF's administrative salaries exceeded the State's limitation for the administrative function.

New York

There are approximately 540 SNFs participating in the Medicaid program in New York. The State cost reimbursement system was essentially prospective in that the rates were based on a projection of allowable historical costs reported by each facility. Each SNF was required to prepare uniform cost reports annually as the basis for the rate computation. The rate computation formula began with total reported operating costs for a base year that was to be used in arriving at the reimbursement rate for the second year after the base year (i.e., costs incurred in 1973 were used in setting the 1975 rate). From this total, costs were reduced by subtracting real property, movable equipment, and automobile costs, which were used later in the computation. Administrators' salaries, including assistant administrators' and relatives' salaries, were subject to limitations both in total and by individual. Costs in excess of these limitations were subtracted by the State from total operating costs. All nonallowable costs identified by State reviewers, such as advertising and food for visitors, were also subtracted by the State from total operating costs.

Two rates were established for each facility to represent the relationship of costs to patient care. The first rate represented costs of administrative, housekeeping, and dietary services, while the second represented the cost of routine nursing care. Rates were computed from the data provided by each SNF and subsequently compared with those established for its respective peer grouping. SNF peer groups are based on size of facility, type of ownership, and geographical location. The ceiling for administrative, dietary, and housekeeping services for each SNF was 110 percent of its group average. Similarly, the ceiling for total allowable costs (excluding property, therapy, drugs, and return on equity) was 115 percent of the group average. Costs above these ceilings were not allowed for rate-setting purposes.

New York had a complicated system for calculating reimbursement rates for real property costs. 1/ Depending on whether the SNF was proprietary and whether the facility was owned by the operator or leased under an arm's-length or non-arm's-length rental agreement, different rules and rates would apply. Generally, if the SNF was owned by the operator, an ownership cost (depreciation, insurance, interest, and a return on equity) would be allowed. If the facility was leased in an arm's-length transaction, the SNF would be reimbursed on the basis of the actual rent or a State "maximum" rent, whichever was less. If the facility was leased from a related party, the SNF would be reimbursed on the basis of the ownership costs of the related party or a State "imputed" rental rate, whichever was greater. The allowable real property cost was then calculated as a per diem rate. Per diem rates were also established for movable equipment costs and auto expenses after ceilings were applied to each. After the various rates had been established, the State added, as appropriate, an inflation factor, an incentive allowance factor, and a profit factor to arrive at the composite or total rate for the following year. However, this rate was subject to revision based on exceptions taken in any field audit performed later by the State.

We analyzed the desk audits for 62 SNFs located in the New York City metropolitan area and noted that of the $112.7 million in costs reported by the SNFs for 1973, the State disallowed $3.1 million, of which $2.1 million (about 2 percent of the costs submitted) was disallowed through the application of the various State ceilings. In addition, the State reviewers determined that these facilities understated costs by about $392,000.

Our analysis of the 210 completed field audits of 98 SNFs showed that of costs totaling about $146 million submitted by SNFs, the State auditors disallowed about $4.8 million (including costs over ceilings), about 3 percent of the amounts claimed. The average field audit disallowance amounted to about $22,800 per report. In addition, the State field audits determined that these facilities had understated costs by $693,000.

1/Several State review commissions have criticized the system on the grounds that the States maximum and imputed rental schedules were arbitrary and unsupported and that the system was subject to manipulation and permitted excessive "cash flow" profits.

We made field audits at one proprietary SNF, one voluntary SNF, and one public SNF in the New York City metropolitan area. All three had been desk audited, but none had been field audited by the State. Of the $27.9 million in costs reported by the three SNFs, we identified $359,000, about 1 percent, which should have been disallowed. The major problems identified were that about $166,000 in Medicare Part B reimbursements for in-house physicians' services were in effect paid twice (by Medicare and Medicaid); $64,000 for capital equipment purchases was simultaneously expensed and depreciated; and $54,000 in interest income was not offset by the State in computing the SNFs' real property cost rate. We reported these findings to the State with the recommendation that overpayments be recovered.

Virginia

There are 35 SNFs in Virginia participating in the Medicaid program. During the 11 months from July 1, 1974, through May 31, 1975, Virginia paid about $4.5 million for SNF care, of which the Federal share was 62 percent. Effective July 1, 1975, the Federal share has been 58 percent.

Virginia paid SNFs on a retrospective cost basis using a modified version of Medicare principles and standards in that the State allowed a growth and development factor, while Medicare did not. [1] During the year, SNFs were reimbursed at an interim rate. Within 90 days after a SNF's fiscal year ends, it must submit a cost report to the State Medicaid agency. The State makes a desk audit of the cost report, reconciles the differences with the provider, and prepares a preliminary cost settlement for the year. After the completion of any field audits, final adjustments are made. If no field audit is made within three years, the preliminary cost settlement automatically becomes final. Also, reimbursement rates for SNFs in Virginia were limited to 150 percent of the State's average per diem cost. In fiscal year 1975 the ceiling was $40.58.

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[1] In July 1975 the HEW Audit Agency issued a report which in part recommended that the State discontinue payment of the growth and development factor on the grounds that the factor was not based on reasonable cost standards. According to a State official, effective April 1976 the State stopped paying the growth and development factor.

We examined seven cost reports submitted by SNFs during fiscal year 1974 to determine the extent of the State's desk audit disallowances. The seven cost reports showed a total of $1,833,000 submitted as the basis for Medicaid reimbursements. During the desk review the State determined that these seven SNFs had a net overstatement of costs of about $39,000, primarily as a result of misstating patient days and underreporting payments for patient care from other sources. The State then added a growth and development factor of $87,000 1/ and applied the State ceiling to reduce the claimed amounts by $168,000, making the total allowable reimbursable costs of the seven SNFs $1,713,000.

Virginia did not use State employees to field audit SNFs. Instead, the State either received the Medicare audit report or when necessary contracted with Certified Public Accountant (CPA) firms to make field audits. A State official told us his goal was to field audit SNFs with significant amounts of Medicaid utilization at least once every 3 years. We audited three SNFs in Virginia, and of $773,000 claimed for Medicaid reimbursement, we found only minor discrepancies. All three SNFs had been desk audited by the State and field audited by Medicare prior to our review.

SUMMARY OF AUDITED COSTS WHICH WERE OR SHOULD HAVE BEEN DISALLOWED

The $9.3 million of costs which were either disallowed or should have been disallowed by the States as erroneously claimed was compiled by analyzing 340 desk and field audits made by the four States and our field audits of 12 SNF cost reports. Erroneously claimed costs amounted to about 3 percent of the $340 million in total costs submitted. However, we noted that only 56 audits (16 percent of the audits) accounted for $6.5 million (68 percent) of the erroneously claimed costs. For these 56 audits, most of which were field audits, the erroneously claimed costs identified were about 5.6 percent of the costs claimed. Overall, the erroneously claimed costs disallowed by State field audits--excluding the application of ceilings--were about 4.5 percent of costs claimed. Most of the disallowances made by the States were based on provisions of the Medicare Provider Reimbursement Manual, which interprets Medicare cost reimbursement principles. The most common types of disallowances were:

1/According to a State official, the State stopped allowing the growth and development factor, effective in April 1976.

- --Nonpatient care revenues, such as income from beauty shops, vending machines, and investments not offset against related expenses. If the nonpatient care revenues are not offset against expenses before cost-based reimbursement rates are calculated, the facility could be paid twice--once as income and again as a Medicaid reimbursement for the cost of the activity that produced the income.
- --Costs not related to patient care, such as advertising in the yellow pages, expenses for luxury automobiles, and vacation trips.
- --Expenses not documented, such as "paper" tax and interest charges and nonexistant invoices. In the case of "paper" charges, no actual payments were made by the facility and the transactions often involved one SNF and another entity closely related to the facility through ownership or control.
- --Costs of capital items being expensed rather than being capitalized. These capital items are such items as wheelchairs, kitchen equipment, and permanent improvements in a building.
- --Costs of capital items being both capitalized and expensed. This results in reimbursing the facility twice during the useful life of the item.

The types of disallowances above were identified in proprietary, private nonprofit, and public SNFs.

Following are examples of unallowable costs identified by State and GAO audits.

Public facility in Massachusetts

This tax exempt municipally owned facility reported costs of $1.1 million for 1973. The State field audit of this facility resulted in disallowances of $223,000, 20 percent of the costs submitted. The adjustments were as follows.

Interest expense

In 1971, Massachusetts enacted legislation allowing the establishment of an authority to oversee, maintain, and operate this municipal facility. On January 1, 1972, the authority assumed operation of the facility. The municipality transferred all assets to the authority under an agreement that the authority would pay the city $345,000 in principal only in annual payments of $15,000 for 23 years. However, interest expense was claimed for this transaction on the basis of a loan repayment schedule calling for combined interest and principal payments at $15,000 annually for 23 years. The interest expense for this and other transactions was disallowed because the State felt they were not arm's-length transactions and did not represent a bona fide expense of the facility. The total disallowed interest expense was about $16,000.

Real estate taxes

Real estate taxes for 1973 were reported at $123,000. This was based on an assessed value of the SNF at $1 million with a tax rate of $1.23 per thousand. Thus, a "paper" tax bill was received by the SNF from the city for $123,000. The agreement transferring the SNF from the city to the authority stated that the property tax payment was actually in lieu of taxes and was payable to the city only to the extent that the claimed property tax payment was actually reimbursed by the State. The $123,000 claim was disallowed by the State auditors.

Other city expenses

The city charged $31,900 to the facility for the city departments of auditor, treasurer, purchasing, and legal services as well as the salary for an employee hired through the Emergency Employment Act. The State auditors disallowed the entire amount because the departments had not done any identifiable work for the facility and the employee's salary had already been paid with Federal funds under the Emergency Employment Act.

Duplicate administrator's expenses

The facility charged $14,400 for the administrator's salary and related benefits which were included on the cost report twice.

Other disallowances

The State auditors made several other disallowances to arrive at the total of $223,000. These other disallowances included

- --$4,000 for pension costs of a retired person and an allocation from the city for services rendered to the facility;
- --$9,000 for physician salaries because such costs were not eligible for reimbursement under the applicable State guidelines;
- --$5,000 for repair expenses which should have been capitalized; and
- --$2,000 for legal services defined by State regulations as not related to the rate appeal process.

Public facility in New York

This county-owned facility submitted calendar year 1973 costs of $14.2 million. These costs were accepted by the State without field audit as the basis for the establishment of the 1975 reimbursement rate. On the basis of our audit, we determined that the costs were overstated by $250,000, about 2 percent of the $14.2 million costs submitted. The overstatements resulted from the following.

Capital equipment

The facility purchased capital equipment for about $64,000 during the year. The purchase was charged as a direct expense and simultaneously capitalized on the SNF's Medicaid cost report, but not on its Medicare cost report. This practice would result in the facility being reimbursed twice over the useful life of the equipment. The practice of charging equipment purchases as a direct expense while simultaneously capitalizing such purchases for Medicaid reimbursement purposes has been in effect since 1969, and has resulted in a total overstatement in equipment costs amounting to about $340,000 as of December 31, 1974.

Reimbursement from Part B of Medicare

In calendar year 1973, the facility received Medicare Part B reimbursements amounting to about $166,000 for in-house physician services provided to patients who were covered by Medicare Part B and by either Medicare Part A or Medicaid. Although this arrangement was properly handled by the SNF in making the cost settlement under Medicare Part A by deducting physicians' salaries applicable to professional services to patients from the costs claimed, neither the payments nor the related costs were deducted in submitting the costs for determining Medicaid reimbursement. Because Medicare Part B and Medicaid covered the same patient days, in effect, this resulted in the SNF being paid twice (by Medicare Part B and Medicaid) for such services. The facility had failed to deduct the Part B reimbursement since 1969; one SNF official estimated that from 1969 through 1973 about $704,000 in Medicare Part B payments had not been deducted in calculating Medicaid reimbursement rates.

Patients' clothing and incidentals

The facility made purchases of patients' clothing totaling about $15,800 during the year.

Purchases should be made using patients' funds and, therefore, not be a cost to the program. The facility has included such purchases in its cost reports since calendar year 1969.

Income from other resources

During 1973, the facility earned revenue of about $1,300 from vending machines and other miscellaneous sources. This income was not offset against operating expenses as required by the State. The facility had failed to offset such miscellaneous income since calendar year 1969.

Proprietary facility in New York

This privately owned facility reported costs for 1970 at $3.2 million. The State made a field audit of the cost report and disallowed about $130,000, 4 percent. Among the unallowable items were

- --$33,000 of interest income not offset against interest expense;
- --$9,800 of transportation expense for luxury automobiles considered by the State criteria as beyond the needs of the facility;
- --$36,800 of capital expenditures charged as an operating expense;
- --$6,500 of salaries paid to relatives through the related management company and deemed excessive by the State auditors;

--$7,600 for public relations expense;

--$5,100 for advertising expense;

--$7,900 erroneously included in office expense actually spent for entertainment charges, unsubstantiated "salaries" paid through petty cash, and public relations expense;

--$4,900 in barber and beautician services, for which patients were also charged; and

--$5,500 in land costs charged to repairs and maintenance.

Proprietary facility in Florida

This private facility reported costs of $407,000 for the year ended December 31, 1973. Florida auditors disallowed costs of $79,000, 19 percent of the total reported. Among the items disallowed were the following:

--$32,700 in owner's compensation, because it was in excess of the Medicare guidelines.

--$23,600 in income from the sale of medical supplies that should have been offset against the medical supply expense.

--$6,100 of interest, because it was paid to stockholders.

--$6,700 for Cadillac automobile and boat expenses and depreciation not related to patient care.

--$3,000 in equipment rental income which should have been offset against related expenses.

--$1,600 income on drugs which exceeded expenses.

--$1,600 in consultant and director's fees.

--$3,700 for other items such as personal travel and entertainment expenses, telephone expenses related to the SNF Comptroller's home phone, auto tires not related to patient care, and income from incidental oxygen sales not offset against expenses.

COSTS DISALLOWED BY THE STATES BECAUSE OF STATE CEILINGS

Field and desk audits made by the four States and our audits disallowed an additional $7.6 million in SNF costs, about 2.2 percent of the costs reported, because the amounts were over the States' (either total or individual) ceilings.

In addition to providing overall limits on reimbursable costs, States' ceilings can also be an effective means for not reimbursing costs which are otherwise unallowable. We noted, for example, that excessive or unallowable costs for one SNF which we reviewed in Florida were not reimbursed as a result of the application of a ceiling.

This 220-bed privately owned facility reported total 1974 costs of $1,625,000. During our audit, we concluded that $303,000 of its reported costs were either excessive or questionable. Following are the items of costs which we believe should have been disallowed. Each of these items was discussed with a State auditor who generally agreed with our conclusion of unallowability or income that should have been offset against expenses.

Proprietor's compensation costs

This SNF had an agreement with a related management firm to provide the facility with management services for a fee of $131,000 for 1974. The main duty of the management firm was to administer the facility. Based on guidelines furnished us by State auditors, we calculated that the allowable administrator's compensation should have been $34,000, and therefore we considered $97,000 of the management fee unallowable. An additional $4,700 in costs included in the cost report was disallowed because it was listed as administrator's salary.

Interest expense

The SNF reported interest expense (including late charges) of $92,900 on notes payable. Our review of this item disclosed that the interest was for loans from a related organization. Discussions with an executive of the management firm disclosed that, although the interest was listed as a cost to the facility, the interest had never been paid and was in fact a paper transaction only. Also, the Medicare Provider Reimbursement Manual provides that interest paid on money borrowed from related organizations is not allowable.

Contributions

Contributions of $26,700 were made by family or friends, apparently on behalf of specific patients. The Florida Medicaid Nursing Home Manual provides that contributions made on behalf of specific patients will be considered as available income to meet the patients' cost of care unless the contributor signs a statement that the contribution is not intended to supplement expenses relative to a particular patient. Such statements could not be provided by the nursing home for 46 of the 53 individual contributors. No adjustment was made to the Medicaid cost report by the facility for these contributions. Therefore, we offset these contributions against the cost report and reduced the allowable cost by the $26,700.

Miscellaneous income

The facility had miscellaneous income for the year of $33,400, which should have been offset against expenses. This income was made up of

--$19,500 for unclaimed patients' deposits treated by the facility as miscellaneous income. We could not ascertain what these patients' deposits were for;

--$13,000 from the pharmacy located in the facility;

--$700 charged patients for laundry, barber, and beauty services; and

--$200 for television rental.

Other unallowable expenses

The facility reported an additional $48,700 in Medicaid costs which were unallowable. This amount included items such as

--$11,000 in overstated medical supplies due to a posting error;

--$8,200 insurance expense included twice in the cost report;

--$5,000 paid a firm to supervise the preparation of financial statements, which was unnecessary since the facility paid a local CPA to prepare the statements; and

--$2,500 in fines levied by the State for noncompliance with staffing standards and other violations.

Misreporting of patient days

On its cost report, the facility reported total patient days of 61,764. During our review, we determined patient days to be 62,397, or 633 more than the facility reported. Reporting fewer days than are actually incurred raises the claimed per diem reimbursement rate.

Total effect of inflated costs

The inflated costs affected the reported daily patient cost by $5.59, as follows:

	Cost reported for 12-month period ended December 1974	Our estimate	Difference
Total expenses	$1,625,420	$1,322,106	$303,314
Patient days	61,764	62,397	633
Cost per patient day	26.32	21.19	5.13
Add 9-percent allowance 1/	28.69	23.10	5.59

Therefore, the unallowable costs plus the errors in reporting patient days could have caused the SNF to have been overreimbursed by $5.59 per Medicaid patient day for 1975. However, because of the State ceiling, the SNF was actually paid $18.08 per day until June 1975 and $19.72 after that time, whereas the amount the facility would have been entitled to in the absence of the ceiling would have been $23.10 a day.

CONCLUSIONS

Two States, Massachusetts and Virginia, used retrospective cost-based systems and two others, Florida and New York, used prospective systems. All four States had provisions for ceilings which had some effect in preventing

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1/The 9-percent allowance is explained on page 6.

excessive reimbursement. Under any system, however, the largest disallowances, in terms of actual dollars and as a percentage of costs submitted, resulted from field audits. Also, field audits seemed to be productive regardless of whether the SNF was private nonprofit, for profit, or a public facility. In general, we identified smaller amounts of unallowable costs in previously field audited nursing homes in Virginia and Massachusetts than in Florida and New York where field audits had not been performed.

CHAPTER 3

EXTENT OF FIELD AUDITS AND PROBLEMS IN RECOVERING OVERPAYMENTS TO SNFs

HEW regulations require the States to assure that appropriate audits are made of records whenever reimbursement is based on costs of providing care or services. However, prior to July 1, 1976, HEW had not issued guidelines defining the required frequency of State audits or standards for making such audits. Accordingly, each of the States we reviewed, although reimbursing SNFs on the basis of cost, varied substantially in their field audit efforts. At the time of our visits:

--Florida had not issued any field audit reports on SNFs since the inception of the Florida Medicaid program on January 1, 1970. After our field visit, Florida did issue reports on 23 SNFs.

--Massachusetts' program provided for field auditing all SNFs each year; however, there was about a 2-year backlog in completing such audits.

--New York had audited only 98 of the 540 SNFs in the State participating in the Medicaid program since the inception of the New York Medicaid program in May 1966.

--Virginia either purchased audit reports from the Medicare intermediary or contracted with a certified public accounting firm to make selective audits of SNFs.

In addition, two of the four States reviewed had problems with collecting overpayments made to SNFs, and Florida had not taken action to collect overpayments. As of June 1976, Massachusetts had about $11.5 million in overpayments to SNFs and intermediate care facilities (ICFs) outstanding for the period 1968 to mid-1973. New York estimated overpayments to SNFs at $3.2 million based on State audits, but had recovered only $1.1 million.

HEW GUIDANCE ON THE FREQUENCY OF AUDITS

Until July 1, 1976, Federal regulations required States to assure appropriate audit of records whenever reimbursement is cost-based without specifying the number or frequency of audits. No distinction was made between field and desk audits.

On July 1, 1976, HEW issued regulations to implement section 249 of Public Law 92-603, which requires that, effective July 1, 1976, payments under Medicaid for SNF services be made on a reasonable cost-related basis. One provision of the regulations requires that all facilities (both ICFs and SNFs) be field audited over a 3-year period beginning no later than January 1, 1978. 1/ Thereafter, in each year a minimum of 15 percent of all facilities in each State must be field audited--5 percent selected on a random sample basis and the remainder selected on the basis of exceptional provider profiles. The regulations require some States to substantially increase their audit capabilities. The status of the four States' field audit capability at the time of our visits was as follows:

Florida

Although the Medicaid program began in Florida in January 1970, as of July 31, 1975, the State had not issued any field audit reports of nursing home costs. However, at that time the State auditors had in process audits of 23 of the 261 nursing facilities in Florida. 2/ Most of these audits were of cost reports submitted for fiscal years 1972 and 1973.

1/A State that can demonstrate that it has in effect a continuing audit program under which it has completed field audits of all SNFs and ICFs in the State during the preceding 3-year period may be exempt from the requirement to field audit all nursing facilities no later than January 1, 1981.

2/The HEW Audit Agency contracted with a CPA firm to perform field audits in six nursing facilities in Florida. The results of these field audits were given to the State by HEW in October 1973. We did not include these audit reports in our review because the State field audited these same facilities for the same fiscal years as part of the 23 audits noted above.

A State official told us the State Medicaid agency had requested the audits because of large amounts paid to a particular SNF or because of indications of overpayments. State health department officials indicated to us that they did not have sufficient staff to make periodic audits of each nursing home. In May 1975, the State Medicaid audit staff consisted of 22 auditors for the entire program, including SNFs. In May 1976, a Florida official informed us that the State had issued its reports on the 23 SNFs.

Massachusetts

Massachusetts, which had 237 SNFs participating in the Medicaid program, determined final cost reimbursement amounts after field audits at each SNF. The State had 14 auditors to make field audits of SNFs, of whom 9 were State employees and 5 were under contract from Blue Cross-Blue Shield. As of June 1976, a State official estimated the backlog of field audits at about 2 years.

As recently as June 1976, the State had not provided its auditors with written procedures or guidelines for making field audits other than the State's annual regulations governing the determination of payment rates.

In June 1976, an official of the Massachusetts Bureau of Welfare Auditing told us that the Bureau had been concerned for a number of months with the specific causes of overpayments to nursing homes. The Bureau is generally concerned with fraud activities of providers, recipients, and State employees for all State welfare programs. As of June 1976, the Bureau had obtained conviction of a nursing home operator and indictment of another for manipulation of their cost reports. In the former case, the operator had manipulated the reported equity for the purpose of claiming extra reimbursement for return on equity and in the latter case patient days were misreported. The Bureau official expected several more indictments during the summer of 1976.

New York

As of July 11, 1975, the State had made 210 field audits in 98 of the 510 SNFs participating in the Medicaid program and was making 142 audits at an additional 58 SNFs. The 352 audits covered primarily cost reports submitted for calendar years 1969-71 and were only for proprietary SNFs. Both private nonprofit and public SNFs were excluded because of the limited staff available for such audits. Until

December 1974, the maximum number of State auditors assigned provider reimbursement activities never exceeded 16. However, as of May 1976, the staff had increased to 153 auditors according to a State official who told us that the State intends to audit all SNFs at least once a year.

In addition to the audits of SNFs routinely performed by the State, a special series of audits was made at selected SNFs and ICFs by the audit staff of the Special State Prosecutor for Health and Social Services. On January 10, 1975, the Governor of New York appointed a Deputy Attorney General to act as Special Prosecutor. In January 1976, the Special Prosecutor released his first annual report, "Investigation into Allegations of Criminality in the Nursing Home Industry in the State of New York." The investigation covered three areas of concern--patient abuse, fraud, and political influence.

In his January 1976 report, the Special Prosecutor reported the filing of 12 felony indictments for fraud and larceny of over $3.4 million. Four convictions had been obtained. The Special Prosecutor's own audit staff had completed 13 audits which identified Medicaid overcharges of $3.7 million and had in process 27 additional audits which had identified an additional $8 million in overcharges. Total costs submitted by all 40 nursing homes were estimated by the Special Prosecutor's staff to be "roughly $200 million." This means that, with less than half the audits finished, a minimum of 6 percent of submitted costs represented overcharges.

Virginia

Virginia has 35 SNFs participating in the Medicaid program, of which 34 also participate in Medicare. Virginia did not use its audit staff to make field audits of SNFs. Instead, the audit staff was used on hospitals and ICFs which represented the bulk of Medicaid payments. For SNFs which provide services to both Medicaid and Medicare, the State purchased the audit reports which it believed would be useful from Blue Cross, a Medicare intermediary. Otherwise, we were told, the State would contract with a CPA firm to make selective audits of SNFs. During fiscal year 1974, Virginia's audit effort on SNFs consisted of purchasing 9 audit reports from Blue Cross. 1/

PROBLEMS WITH COLLECTING OVERPAYMENTS FROM SNFs

There are no uniform Federal requirements for State recovery systems. 2/ We believe, however, that the cost effectiveness of any State provider audit program depends to a large extent on the State's capability to actually recover overpayments identified during audits. Two of the four States that we reviewed had problems collecting overpayments from SNFs; only one appeared to have an effective collection program, while another had no collection program at all.

Florida

According to a State official, Florida has never recovered any payments from SNFs for any reason. The official told us, however, that the State could recover any overpayments that were found to have been made in connection with its recent field audits of 23 nursing facilities.

Massachusetts

In June and July 1971, the HEW Audit Agency reported that nursing homes in Massachusetts were overpaid $915,000 and recoveries had not been made. These overpayments occurred because the State failed to make retroactive adjustments for 1969 when the 1969 interim per diem rates were lower than the 1968 interim rates. These nursing homes were paid at the 1968 interim rates until the 1969 interim rates were established. SRS offset a subsequent State claim for Federal financial participation by the Federal share of the $915,000 ($457,000) as a result of the two 1971 reports.

1/The HEW Audit Agency field audited six Virginia nursing facilities (one SNF and five ICFs) and turned the results over to the State in July 1975. Because the findings pertained primarily to ICFs, we did not include these audit reports in our analysis of disallowances.

2/Under the regulations issued July 1, 1976, States are required to account for overpayments identified through State audits on the quarterly Statement of Expenditures submitted to SRS. This accounting must occur no later than the second quarter following the quarter in which the overpayment is found.

In February 1974, the HEW Audit Agency issued another report on the Massachusetts Medicaid program which pointed out that

--the State had not recovered from the nursing homes the $915,000 in overpayments cited in the 1971 reports even though SRS had recovered the Federal share from the State,

--overpayments continued to be made without recoveries, and

--SNFs and ICFs had been overpaid by at least an additional $1.9 million for 1970 and 1971.

The report went on to recommend that the State either credit the Federal account for the Federal share of the $1.9 million ($950,000) or develop on a timely basis a systematic plan to recoup overpayments.

The State chose the option of establishing a recovery system. An SRS official told us that after several months SRS started procedures to recover the Federal share of the $1.9 million from the State because of the State's failure to make satisfactory progress in establishing an effective system. State appeals to SRS delayed SRS's attempted recovery. Collections and offsets made by the State reduced the outstanding balance to $405,000 by March 1976. In August 1976 an SRS official told us that he was recommending that SRS stop further actions to recover the Federal share of this balance. Both State and SRS officials told us that the State's recovery system was not satisfactory, but they all believed that progress was being made.

In May 1975, a Massachusetts official estimated that $11.5 million was outstanding which had been overpaid to 340 SNFs and ICFs from 1968 to mid-1973. The State did not know how much it had actually overpaid facilities since mid-1973 because its automated accounting system for retroactive adjustments was programed only to handle underpayments. SRS had not required the State to change its automated accounting system to tabulate overpayments made to SNFs.

In June 1976, another Massachusetts official told us that although some part of the $11.5 million overpayments estimated in May 1975 had been recovered, additional overpayments to nursing homes identified by the State auditors after May 1975 would probably make the outstanding overpayments around $11.5 million as of June 1976. However, he could not supply us with any data to support this estimate. He also noted that since "final" rates are subject to appeal, not all of them can be considered final. Pending appeals of final rates go back as far as 1970. In June 1976, another official told us that there were about 1,600 pending appeals of both interim and final rates. Appeals of interim rates are normally dropped when the final rate is established, although the final rate is, of course, subject to appeal. Also, until April 1976, the State did not have a systematic procedure for recovering overpayments after they were identified.

New York

New York did not have an effective program for recovery of overpayments made to SNFs. In July 1975, a New York State official estimated that the State was entitled to recover about $3.2 million as a result of rate adjustments based on State audits of SNF costs. Actual recoupments, however, have amounted to only about $1.1 million, about 34 percent of the estimated total due the State. The Federal share of this amount outstanding is 50 percent. In May 1976 a State official told us the State Medicaid agency was developing repayment schedules so that outstanding overpayments could be recovered, but these repayment schedules had not been finalized at that time.

Virginia

Virginia uses Medicare policies for recovering Medicaid overpayments to SNFs. Upon determination that money is owed to the State, the provider is notified and requested to make repayment. If repayment or acceptable agreement for repayment is not reached within 120 days, the State gives the provider 30 days' notice that current interim payments will be stopped. Acceptable repayment arrangements include a reduction in the interim rate, full repayment, installment repayments, or offsets against the following year's cost settlement. At the time of our visit in July 1975, no SNFs owed the State because of outstanding overpayments.

CONCLUSIONS

Federal regulations require that States assure appropriate audit of records whenever reimbursement is based on costs of providing care or services. All of the States we reviewed were reimbursing SNFs on either a prospective or retrospective cost basis, yet each State varied in its audit effort from no completed audit reports in Florida to a requirement in Massachusetts that all SNFs be audited prior to the annual retrospective final settlement. However, HEW issued regulations on July 1, 1976, that will require many States to increase their audit efforts.

Also, Massachusetts and New York were having difficulties collecting overpayments made to SNFs, and Florida had not taken action to identify or collect overpayments. Only Virginia, which has a small SNF program and which has adopted Medicare's procedures for systematically identifying and recovering overpayments to SNFs, seemed to have an effective program.

RECOMMENDATIONS

In order to better assure that overpayments made to SNFs and ICFs are either recovered or offset against current payments, we recommend that the Secretary direct the Administrator of SRS to

--periodically assess States' actions to comply with the recently issued regulations requiring States to identify and report overpayments to SNFs and ICFs on a timely basis and

--deny Federal participation in overpayments when States do not establish effective recovery programs on a timely basis.

CHAPTER 4

PROGRESS IN IMPLEMENTING A NATIONWIDE CONVERSION TO COST-RELATED REIMBURSEMENT SYSTEMS

HEW has been slow in issuing regulations requiring States to reimburse SNFs on a reasonable cost-related basis by July 1, 1976. HEW did not issue final regulations until July 1, 1976. The regulations permit States to delay implementation until January 1, 1978, 18 months after the statutory effective date. HEW estimates that the additional cost to the Medicaid program for SNF services, as a result of implementing the proposed regulations, will be about $117 million in payments to SNFs for the first full year of implementation.

HEW PROGRESS IN ISSUING REGULATIONS

Section 249 of Public Law 92-603, enacted October 30, 1972, requires that, effective July 1, 1976, payments under Medicaid for SNF services be made on a reasonable cost-related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary.

SRS issued its first proposed regulations to implement section 249 in March 1975. The preliminary draft regulations were distributed at the State Medicaid directors meeting held on March 24-26, 1975, to the State directors in attendance and to representatives from HEW regional offices. In addition, copies were mailed to those States not represented at the meeting.

The draft regulations initially proposed by SRS met opposition from within HEW as well as from the States. The Office of the Deputy Assistant Secretary for Planning and Evaluation/Health commented that the draft regulations were too permissive and lacked clear Federal guidance regarding the type of cost-based payment systems that would be acceptable within the statutory requirement that they be "reasonable cost-related." By letter dated June 27, 1975, the Office made a series of specific suggestions for strengthening the proposed regulations, including recommendations relating to cost features, reimbursement policy, and specified minimum audit priorities and frequency. Some States opposed the reasonable cost-related feature of the conversion mandate because they expected increases in program costs.

HEW formally issued proposed regulations to implement section 249 on April 13, 1976, and final regulations on July 1, 1976.

Among the provisions included in the final regulations are these:

--The Medicare reasonable cost reimbursement formula may be used. State systems following Medicare principles of reimbursement would have automatic HEW approval.

--Rates of payment may be determined propsectively or retrospectively.

--Reimbursement rates within a State may be determined on a class basis.

--State reimbursement rates for routine services must include payment for regular room and board, nursing services, special diets, minor medical and surgical supplies, and the use of equipment and facilities.

--States may establish reasonable ceiling limitations based on costs for the efficient delivery of service. Limits on costs must be established at levels adequate to permit adherence to health and safety standards for participation in Medicaid.

--Field audits must be performed at all SNFs and ICFs over a 3-year period beginning not later than January 1, 1978, unless the State already has an acceptable field audit program.

--Medicare audit standards are recommended, but each State may develop its own audit standards which are consistent with standards approved by the American Institute of Certified Public Accountants.

Until the final regulations were published, it was not possible to identify what changes, if any, needed to be made in each State's reimbursement system. As noted above, the States may delay full implementation until January 1, 1978. In the preamble to the final regulations, HEW acknowledged that its delay in publishing regulations made it impossible for many States to comply with the July 1, 1976, effective date for implementation of section 249. We agree that many States will require a period of time to make changes in their reimbursement systems. It seems clear to us that the Congress was aware that a period of time was needed to make changes in State reimbursement systems when it provided from October 1972 until July 1976 to bring about implementation.

COST OF IMPLEMENTING COST-RELATED REIMBURSEMENT SYSTEMS

In September 1975, SRS requested its regional offices to obtain from each State a financial impact statement so that SRS could prepare an inflationary impact statement for implementing the changes required by section 249. Based on these statements, 1/ SRS estimated that the additional costs to the States and the Federal Government for SNF services would be about $117 million, approximately 4 percent of total payments to SNFs nationwide. The estimated increase includes $44.8 million for Ohio, which did not submit a financial impact statement, and $17 million for Illinois, which stated it could not estimate the impact of the proposed regulations. SRS made estimates for both States based on a comparison of the then-current average reimbursement rate in Ohio and Illinois to the average rates paid in adjacent States.

Pennsylvania reported that the conversion would cost the State an increased $35.6 million for SNF care. However, an HEW General Counsel memorandum pointed out that Pennsylvania's reimbursement procedures for SNFs might not be in accordance with the existing Federal regulations because the State paid publicly owned facilities on a different basis than it paid privately owned facilities for similar SNF services. Public SNFs were paid on the basis of reasonable costs and private SNFs were paid a flat rate. An SRS official stated that if Pennsylvania was not in compliance with Federal regulations

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1/The estimates were based on the assumption that all cost related reimbursement systems would be fully implemented as of July 1, 1976, and the time period for which increased costs were to be estimated was July 1, 1976, to June 30, 1977. The assumption turned out to be unrealistic as a predictor of when full implementation would take place, but it did serve to eliminate any obvious bias in the estimate due to differing perceptions of when implementation could take place.

and had to pay all SNFs on a reasonable cost basis as it paid public SNFs, there would be a substantial reduction in the estimated increased costs for the section 249 conversion. The SRS official also stated that it is unlikely Pennsylvania would want to meet the equal payment requirement by paying public SNFs a flat rate for SNF care because all costs above the flat rate would then be borne by the State without Federal financial participation.

In addition, there are a number of features in the July 1976 regulations that we believe could help to hold down the costs of SNF care, such as authorizing ceilings and requiring field audits.

CONCLUSIONS

Although Public Law 92-603 was enacted on October 30, 1972, HEW did not issue final regulations for the implementation of section 249 until July 1, 1976. Until the regulations were issued it was not possible to identify the changes, if any, to be made in State reimbursement systems. Consequently, some States were not able to implement the changes by July 1, 1976, as mandated by the law.

The implementation of section 249 undoubtedly will cause some States and the Federal Government to spend more money on SNF and ICF services. However, we believe that the regulations contain features such as authorizing reimbursement ceilings and requiring field audits that could enable the States to minimize the financial impact of changing to a reasonable cost-related system of reimbursement.

SCHEDULE OF COSTS ERRONEOUSLY CLAIMED BY SNFs,
COSTS OVER STATES' CEILINGS, AND UNDERSTATED COSTS

State	Type of audit	Number of audits	Total costs submitted	Costs erroneously claimed	Costs over State ceilings	Total costs disallowed	Understatement of costs
Florida	Desk audits	25	$ 18,301,720	$ 160,889	$2,646,142	$ 2,807,031	$ -
	Field audits	10	7,285,639	1,226,376	155,790	1,382,166	-
	GAO audits	3	2,759,036	40,946	321,907	362,853	-
Massachusetts	Field audits	26	19,172,470	2,461,644	1,475,540	3,937,184	1,065,079
	GAO audits	3	3,481,611	22,202	18,686	40,888	-
New York	Desk audits	62	112,705,512	963,641	2,095,518	3,059,159	392,218
	Field audits	210	145,922,754	4,075,302	710,333	4,785,635	692,570
	GAO audits	3	27,938,547	320,265	38,259	358,524	-
Virginia	Desk audits	7	1,832,706	68,183	167,575	235,758	116,390
	GAO audits	3	773,070	1,577	-	1,577	-
	Total	352	$340,173,065	$9,341,025	$7,629,750	$16,970,775	$2,266,257

PRINCIPAL HEW OFFICIALS RESPONSIBLE FOR THE ADMINISTRATION OF ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
David Mathews	Aug. 1975	Present
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
Robert Fulton	June 1976	Present
Don I. Wortman (acting)	Jan. 1976	June 1976
John A. Svahn (acting)	June 1975	Jan. 1976
James S. Dwight, Jr.	June 1973	June 1975
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:		
M. Keith Weikel	July 1974	Present
Howard N. Newman	Feb. 1970	July 1974
Thomas Laughlin, Jr. (acting)	Aug. 1969	Feb. 1970
Francis L. Land	Nov. 1966	Aug. 1969

OTHER NURSING-HOME-RELATED REPORTS

ISSUED SINCE 1972

Report title	Number	Date issued
Federal Fire Safety Requirements Do Not Insure Life Safety In Nursing Home Fires	B-164031(3)	6- 3-76
Improvements Needed In Medicaid Program Management Including Investigations Of Suspected Fraud and Abuse	MWD-75-74	4-14-75
Improvements Needed in the Managing and Monitoring of Patients' Funds Maintained by Skilled Nursing Facilities and Intermediate Care Facilities	MWD-76-102	3-18-76
VA Community Nursing Home Program	MWD-76-97	3- 8-76
Error in Veterans Administration's Calculation of Community Nursing Home Rates in Medical District 5	MWD-76-50	10-24-75
Increased Compliance Needed with Nursing Home Health and Sanitary Standards	MWD-76-8	8-18-75
Many Medicare and Medicaid Nursing Homes Do Not Meet Federal Fire Safety Requirements	MWD-75-46	3-18-75
Need to More Consistently Reimburse Health Facilities Under Medicare and Medicaid	B-164031(4)	8-16-74
Better Use of Outpatient Services and Nursing Care Bed Facilities Could Improve Health Care Delivery to Veterans	B-167656	4-11-73
Problems in Providing Guidance to States in Establishing Rates of Payment for Nursing Home Care Under the Medicaid Program	B-164031(3)	4-19-72
Summary of Reviews of Planning, Construction, and Use of Medical Facilities at Selected Locations	B-167966	3- 7-72

Mr. Rostenkowski. Thank you, Senator. I had the opportunity to sit with Mr. Halamandaris and have an exchange of ideas with respect to what has been happening in New York and Chicago.

I certainly appreciate the fact you took the time out of a busy schedule in the Senate and had the courage to go out and find and uncover all the things that were happening. It is almost repulsive to me that we have in our society a group of people that want to take advantage of those people that are really sick and to waste the taxpayers' money as they have.

I think this is truly a commitment on the part of Mr. Rogers and his subcommittee and mine as well to do something about this and to give the kind of care that people are entitled to.

I think you have done great service and I am proud to be associated with you.

Senator Moss. Thank you very much.

Mr. Rogers. I certainly share those feelings. I think it would be helpful if we could also, as we go into a consideration of both of these programs, to have your thinking as to changes that might be helpful in meeting the situation. Also, I wondered, did you concentrate mainly on medicaid or did you find similar problems with medicare?

Senator Moss. Well, we concentrated mainly on medicaid. Medicare has its problems, but they are somewhat different from this.

Mr. Rogers. Yes. Well, I think you have done a tremendous service. We have been most impressed with the work that has been done. Certainly your work and the foundation you have laid will be helpful to us in trying to bring some action.

Thank you.

Mr. Duncan. I have no questions.

Mr. Rostenkowski. Dr. Carter?

Mr. Carter. I wanted to commend the Senator for his work. It is very interesting and certainly will be helpful. You uncovered abuses which must be eliminated. There is no question about it. I commend you for your very worthwhile work.

Senator Moss. Thank you, Doctor. I am very confident now with the focus that you have on this in this committee we will be able to get to some of the problems. The long-term solution is still not entirely clear, but at least the short-term measures we can take.

Mr. Rostenkowski. Mr. Maguire?

Mr. Maguire. I have no questions, Mr. Chairman. I thank the Senator very much for his able work in this field.

Mr. Rostenkowski. Thank you again, Senator.

Mr. Woodcock?

Welcome to the committee, Mr. Glasser.

STATEMENT OF MELVIN A. GLASSER, DIRECTOR, SOCIAL SECURITY DEPARTMENT, UNITED AUTO WORKERS, ON BEHALF OF LEONARD WOODCOCK, PRESIDENT AND CHAIRMAN, HEALTH SECURITY ACTION COUNCIL

Mr. Glasser. Mr. Chairman, I am obviously not Mr. Woodcock. I am Melvin A. Glasser, Director of the Social Security Department of the UAW. I am testifying in behalf of the UAW and the Health

Security Action Council, and I bring the apologies of Mr. Woodcock, who as you doubtless know has just agreed to go on a Presidential mission to Vietnam and has had to engage in drastic reorganization of his schedule in connection with that trip. Therefore, he asked me to convey his regrets that at the last moment he had to change his planned testimony this afternoon.

Mr. Rostenkowski. Thank you, Mr. Glasser. We certainly are looking forward to your testimony.

Mr. Glasser. Thank you.

Mr. Woodcock particularly wanted me to express his appreciation to the chairmen and the members of both committees for the decision to hold a joint hearing on this important subject, and he hopes it will be the beginning of many joint activities in the health area in the interests of expediting and augmenting the process of deliberation of the committees and of the House.

Enactment of this bill would, indeed, strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicaid and medicare programs. We support its provisions in section 2 to clarify the ban on factoring arrangements to physicians and other providers.

We support the provisions in section 3 requiring providers' and suppliers' disclosure of ownership. We feel that not enough attention has been given to this and we hope it will be in the bill. We understand that Congressmen Moss and Rogers are proposing an amendment to require a uniform system of cost accounting for institutional providers of service under medicare and medicaid. While we have not yet seen the details of the amendment, we heartily endorse its objectives.

With regard to section 4, we support the provisions for penalties for providers or suppliers for defrauding medicare and medicaid. We would generally oppose, however, the provisions for penalties to beneficiaries or recipients. We hold that health care is a right and not a privilege.

We do not believe that "abuses" by patients of entitlement conditions should in any way be equated with fraud and abuses by providers. While imprisonment of people who have received needed medical care when they weren't entitled to it under medicaid could actually be an assistance in some cases, considering the difficulties and abuses they experience in medicaid mills and other settings, we find abhorrent the idea that anyone could be sent to prison for up to 1 year for seeking relief from pain and suffering even though they were not medicaid entitled. The present provision in the law, which is carried over into the new legislation, is much too harsh. The real perpetrators of fraud are the nursing home operators, business cheats and some doctors — not the relatively few patients who have to cheat because they have no other way to get medical care.

What makes anyone think that people just love to have blood tests, urology workups, and tooth extractions? Recently in Maryland, a dentist billed medicaid for filling 11 teeth of a patient for whom he had previously billed medicaid for 33 extractions. If that patient had not actually been entitled to medicaid "benefits," he could have been sent to jail or fined $10,000 under H.R. 3 for defrauding the program.

The legislation would permit authorities to suspend for 1 year a beneficiary who is convicted of misrepresentation or other misdemeanors listed in the bill. In the case of the beneficiary without teeth in Maryland, the blessing of suspension would be too late.

What if the person who is eligible for medicaid "abuses" the program by seeking unnecessary services? In our opinion, the provider must be held to account. It is the provider who determines the need for the service and it is only the provider who benefits from the transaction.

We are in agreement with provisions in section 5, dealing with PSRO's as they apply to fraud and abuse, but are concerned about their broader implications. Beyond punishing fraudulent activities, the authors of the bill do not impute to it any long-range characteristics or guidelines of a national health insurance program.

We ask, why not? If the responsibility and authority of PSRO's are to be broadened somewhat as proposed in H.R. 3, why not give them the means and the characteristics really needed to do the job right? The PSRO section already goes beyond fraud and abuse. It provides that when the Secretary finds a PSRO competent, then that PSRO's reviews shall constitute the conclusive determination of payment under this act, and other reviews—presumably including claims reviews—will have no applicability to the programs covered by the act.

But as we all know, PSRO's are still largely unproved instruments of quality and cost control. Their work applies only in the hospital sector. They have no authority and little, if any, experience in the ambulatory care field. No PSRO to our knowledge has yet been accused of any vigilant crackdowns on doctors. For the vast amount of hospital stays, the PSRO's have not made many negative decisions as to the necessity or appropriateness of care.

If the PSRO's are to help achieve the goals of H.R. 3, their authority must go a lot further than that provided in H.R. 3. The health professions must be generally represented on the PSRO's. Full public accountability must be assured. Up to now, the costs of PSRO's have been high and productivity and impact low.

I think that in his initial proposal on hospital cost containment President Carter has shown us the direction to go with PSRO's. He has proposed cost containment across the board and not just with respect to medicare and medicaid. He knows and so should we that you can't control hospital costs by limiting the liabilities of medicare and medicaid. You can only control hospital costs by paying hospitals differently than they are now being paid.

If limited payments apply only to Federal costs, the hospitals will shift higher charges to patients, State and local governments, workers and employers. There must be prospective budgeting of a hospital's entire costs, with regional negotiation of the budgets so as to reduce duplication and waste both within the hospital and within the community it serves.

But can you control hospital costs even with prospective approved budgets when the physician is given free rein to overorder services and utilization? And if you can, do you not invite overutilization by physicians of the ambulatory care services they provide when you tighten the screws on hospitals, but apply no conditions on ambulatory care?

And if we are, indeed, talking about cost containment, we suggest that such a provision be included in this bill.

We believe the PSRO's should function in the ambulatory care field as well as in the hospital. When you add up the relative costs, abuse is really much more of a problem than fraud.

Subpar services in overpriced nursing homes turning fat profits at the expense of helpless patients. That is abuse.

Lab charges that are ridiculous, in addition to the abuses listed by Senator Moss. That is abuse.

Gang visits and ghost surgery. That is abuse.

Needless surgery—an estimated 2.4 million unnecessary operations in a single year, according to another congressional subcommittee. That is abuse.

By continuing to support thousands and thousands of unnecessary hospital beds, we invite both overutilization and an intolerable waste of resources. It has been estimated that we have at least 50,000 unnecessary hospital beds in the country. That, I should add, is an exceedingly conservative estimate.

Maintaining them costs $2 billion annually. That is real abuse. By comparison, the medical frauds are pikers, despite the horror stories.

We know it must be frustrating to attempt to deal with these problems. Abuse is a very complex matter. It is not likely to be significantly affected by this bill because abuses are built into the full system of health care of which medicare and medicaid are only a part. The approach taken in this bill has very real limitations.

Each month the health care bill, as you ladies and gentlemen know, in this Nation averages $1 billion more than the corresponding month last year. A time bomb is ticking away and it won't be defused by H.R. 3 even with its worthy features, which we fully support.

The 1972 medicare/medicaid amendments established PSRO's and set limitations on reasonable cost reimbursements and on capital expenditures. The goal is certainly worthy, but we believe unreachable by patchwork programs. Only during the economic stabilization program were hospital prices and physician fees restrained. Since the end of that program, as before, they have escalated at twice the rate of other consumer prices. Even during the program, expenditures for hospital and physician services rose much faster than controlled prices.

Health services now absorb almost 9 percent of our GNP. They will continue to consumer an increasing share of our Nation's resources until such time as we have a national health insurance program which deals comprehensively and concurrently with reform of services. That is why we strongly support the Health Security bill.

The across-the-board, closed-end budgeting approach of the Health Security bill offers our best hope for restraint of costs without impairment of quality. The Health Security bill recognizes that the hospital and the physician are both part of the system and they impact upon one another. In his major health speech before the Student National Medical Association last April—the speech which the President recently asked the HEW staff to read—he stated:

> "The complex reality is that health care is one strand of a seamless social web. Our Nation's health problems must be attacked from many approaches, one of which is national health insurance. We must begin by considering how we best can spend the health dollars."

With his proposal on across-the-board hospital cost controls, the President has been true to his word and has begun at the beginning. Your concern with detecting and preventing fraud and abuse in medicare and medicaid may well serve its most useful social interest if these hearings and the legislative process initiated here lay the groundwork for the basic reforms of the health care delivery system and its overall financing, which you will later consider in national health insurance proposals.

Mr. Chairman, we fully support your objective of eliminating fraud and curbing abuse of the medicaid/medicare programs. We know you recognize, however, that a bill like H.R. 3 can only in a very modest way offer correction of the major problems faced by the Nation's health care program.

Mr. Rostenkowski. Thank you, Mr. Glasser. I am somewhat surprised that in your statement you strongly oppose maintaining even existing penalties to beneficiaries or recipients. It is a misdemeanor now. We don't change that at all; but don't you think that the person that is a recipient who sells his medicaid card to another person who is more affluent for the purposes is defrauding the Government? Don't you think he should be prosecuted?

Mr. Glasser. Well, I would like us to look at this in perspective. We almost equate this with the nursing home operators whom we heard Senator Moss testify about a few minutes ago. Let's look at what we are talking about:

In the first place, these are certainly a minor part of the problem, an exceedingly minor part.

Mr. Rostenkowski. I agree it is a minor part. But, should there be no penalty at all?

Mr. Glasser. Let's look at for a moment what we are talking about. We have an illustration of a medicaid eligible recipient selling a card for a few dollars to somebody who is going to subject himself to the demeaning services rendered under medicaid. Why? Because he probably falls a few hundred dollars above that State's maximum for eligibility. He is not selling his medicaid card to a middle class person who wishes to enjoy the pleasures of medicaid mills.

Sure we have got to deter that, but to have the kind of penalty that says such a person, for selling his card to another person who needs medical care and can't get it goes to jail—that is the problem—he needs medical care and can't get it, put him in jail for a year; I suggest that is not good public policy. We support a penalty, certainly, but of a lesser nature.

Mr. Rostenkowski. If you don't have a penalty, the abuses that we have uncovered will be absolutely nothing compared to the violations that can ultimately take place in this area.

Mr. Glaser. Our view, sir, is that in comparison with the abuses—I correct that, with the fraud perpetrated by providers, and in view of the fact that these situations and there are not many, are largely as a result of the fact that the right to medical care has been denied to these people, minor penalties in no way comparable to those in section 4(1) would be appropriate. But $10,000 and a year in jail seems to us heinous in a country where somebody is using a medicaid card because he needs medical care and can't get it.

Mr. Rostenkowski. That is current law, you know, Mr. Glasser. That is up to $10,000 and a year in jail. That is at the discretion of the court. I really feel that these hearings were initiated because of the abuse and the fraud that has taken place. To say that we should eliminate penalties at the lowest level really isn't the foundation upon which I think we can build a record also to write revisions in the law that will deter people.

Mr. Glasser. Mr. Rostenkowski, obviously it is in present law. But the committee is writing a new law. Every provision, we know, the committee would wish to examine on its own merits. We think there is a very unfortunate provision in here that unfairly prosecutes a number of individuals and subjects them to severe penalties, when in fact the amount of fraud deriving from this is indeed a miniscule part of the losses resulting in the program; and, if I might say sir, there hasn't been enough investigation and prosecution in all areas of fraud as the committee has heard all morning.

Mr. Rostenkowski. We have heard that. We heard that all morning.

Mr. Glasser. We haven't heard much. But if indeed these legions of investigators are employed and they begin cracking down and we are subject to the vagaries of a variety of judicial systems and judges, we will have people who needed medical care and bought a medicaid card or borrowed one for $10 to go see a doctor spending up to 1 year in jail.

I would say to you in terms of equity in the system, that this ought to be in a minor way either removed or made a minor offense.

Mr. Rostenkowski. Right now it is a minor offense. It is a misdemeanor.

Mr. Glasser. Well, I do not consider 1 year in jail and a $10,000 fine a minor offense.

Mr. Rostenkowski. That is the maximum penalty.

Mr. Glasser. It is, but what protection do we have against the judge imposing it?

Mr. Rostenkowski. None, other than judicial restraint.

Mr. Glasser. That is why I suggest it is much too severe.

Mr. Rostenkowski. You suggest in your testimony that the authority and responsibility of PSRO's should be broadened beyond what we have in H.R. 3; the bill would now require PSRO's to review ambulatory care services of physicians and increase public accountability be requiring the Secretary to report annually to the Congress, both of which you recommend. What else would you recommend to be done with respect to duties of a PSRO?

Mr. Glasser. Review of physicians services in their offices. That is essentially what we are talking about. That was in the Senate bill as you may know, and at the last minute was eliminated; and since that is indeed an essential part of the problem the committee is now talking about, the problem in the health care system, it seems to us that it makes good sense to include it.

Mr. Rostenkowski. Mr. Rogers?

Mr. Rogers. Thank you very much, Mr. Chairman.

As I understand it, you support this. You feel that the penalties should be lessened in one area, but think they should be made more severe for providers; and as I understand it, you say until we get national health insurance, this really would not have much effect since it only goes to abuse?

Mr. Glasser. That is essentially correct.

Mr. Rogers. I am not sure on—and I won't get into this now; should we put closed-in budgeting on medicare or medicaid?

Mr. Glasser. The problem, it seems to me, Mr. Chairman, is that——

Mr. Rogers. I thought as an experiment, before it went nationwide, should we try closed-end budgeting with medicare and medicaid?

Mr. Glasser. The problem with closed-end budgeting, in my view, on medicare and medicaid, is that it is not nearly enough in the sense that closed-end budgeting on those two programs, as President Carter has indicated he understands, in effect will simply move the excess costs over to the rest of the system, namely, the private sector, everybody else in the system. Unless one could have closed-end budgeting which you know from previous testimony before your committee we favor—unless you have it for the whole system, the costs are simply transferred to the private sector.

Mr. Rogers. If I may be permitted, it couldn't move because it wouldn't have the money.

Mr. Glasser. If one had closed-end budgeting on medicare-medicaid and paid hospitals on a limitation—is that essentially the question?

Mr. Rogers. I am asking you what you thought would be an experimental way of trying to use closed-end budgeting before we move the whole national system into it.

Mr. Glasser. Well, unless one grasps the whole thing, you just can't make it. Now, I want to make one other comment in this connection, because these are indeed unique kinds of hearings with a unique subject.

We have 61 other nations in the world, including Canada, which is not unlike us, which have either a national health insurance or a national health service program. Now, it is interesting that to my knowledge not a single one of them has the kind of serious problem with fraud that we have in the United States; and I suggest to you, sir, that one of the reasons is that they have addressed their problems in totality, as a whole, and by the way in which we in the United States have designed the medicaid system particularly, it lends itself and encourages fraud. We abhor fraud in health care. We believe our programs, through their design, make fraud relatively easy.

Mr. Rogers. Freedom of choice?

Mr. Glasser. Freedom of choice, of course, freedom of choice among providers and among delivery systems, both.

Mr. ROGERS. You see, in Canada now they are putting a cap on the Federal contribution and they are beginning in the provinces now—to take away services.

Well, I won't get into this.

Mr. GLASSER. I would be glad to respond to that, but that would take us off.

Mr. ROGERS. On the budgeting——

Mr. GLASSER. They had budgeting for hospitals in Canada for 17 years.

Mr. ROGERS. I understand.

What I was concerned with was in looking at putting some cost controls in this budgeting process that you are talking about, is there a possibility for implementing these two programs? Now, I take it from your answer you think it is not?

Mr. GLASSER. I would put it to you this way, Mr. Rogers. As a representative of probably the largest nongovernmental purchaser of hospital care services through our negotiated contracts, every evidence that we can find in studying the situation is if you have prospective budgeting of hospitals and/or other providers—for only the medicare-medicaid pieces, two things will happen:

The Gresham's law of medical care will apply, namely, largely the poor providers will be willing to provide medical care to the medicaid-medicare recipients; and, two, increasingly, there will be transfer from the public sector to the private sector, namely, the kind of people I represent, of the excess costs that they can't get out of the Government; and I am sorry to say that after years of working with this, I cannot leave out the analogy of a balloon. Health care is a large balloon, unfortunately full of helium. If you squeeze any end of the balloon, you hold down that part of it; but the rest of it gets fatter. Unless on deals with the whole balloon, it is really not possible—and we have had evidence over 30 years now that to grab that little piece and hold it tight.

Mr. ROGERS. Would this be true with cost controls being imposed on hospitals alone?

Mr. GLASSER. The President apparently—and we do not know the details—is proposing them across the board for the entire sector of health care rather than the public program alone. We won't know that for another couple of weeks.

Mr. ROGERS. At the physician's office?

Mr. GLASSER. No, sir.

Mr. ROGERS. I thought it was only in institutions?

Mr. GLASSER. Yes; and therefore will have limited utility but it may have some.

Mr. ROGERS. Thank you very much.

Mr. ROSTENKOWSKI. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

You have given a rather interesting statement. You have 33 teeth, one more than an individual normally has.

You said you were opposed to fraud, and I would hope you are; but actually your statement here sort of is different to what you say, really. In this you said it was all right for a person to use a medicaid card of someone else and get treatment. I think that by saying that, you do condone fraud; and I regret—it would seem that way. I don't really believe you mean that. Actually I think that any physician who is worth his salt, my good friend, is going to see any patient who is ill and do his best for him. If he doesn't he's not living up to the ethics of his profession. I know—go right ahead.

Mr. GLASSER. Dr. Carter, I want the record to be clear: and that is, my statement is that to equate the fraud of an individual who buys a medicaid card so he will have the privilege of going to a medicaid mill to get medical care, to equate that with the nursing home operator who buys Corots, Manets and Degases with medicaid moneys in my view is abhorrent.

Mr. CARTER. I agree with you, those practices of medical mills are abhorrent. I certainly want to see them ended.

Mr. GLASSER. I suggest to you in behalf of the consumers in this country, the patients, the poor folks who may or may not be above that arbitrary minimum—and I remind you most States now do not have medicaid eligibility for the so-called medically-indigent—the law makes it possible as you well know—since most States do not, it seems to me that if an individual is desparate enough to resort to this practice to get medical care in a country where it's generally viewed to be a right, his circumstances should be understood and the penalties less severe than stipulated in this bill.

Mr. CARTER. Let's not let that be necessary. Let's treat him if he is ill, without forcing him to commit—or to take another's card. Let's give him treatment before that.

Mr. GLASSER. I certainly hope you can be back before this committee and get your support for a national health insurance bill that will do that.

Mr. CARTER. I have a bill that will do that, right now.

Mr. ROSTENKOWSKI. Mr. Walgren.

Mr. WALGREN. No questions.

Mr. ROSTENKOWSKI. Mr. Duncan?

Mr. DUNCAN. Thank you, Mr. Chairman.

All the reports that we have received here today, including Sena- Moss' and others that I have read fraud and abuse largely is in the large urban centers, not in the smaller States or the rural States. What are your thoughts on that?

Mr. GLASSER. Mr. Duncan, I think it follows the Willie Sutton principle. He used to rob banks because that is where the money was. I think, frankly, because there are more poor people in the urban centers, they are congregated——

Mr. DUNCAN. I am not talking about cities of 500,000 people or less. I am talking about Chicago, New York. Is it just lack of management of local government?

Mr. GLASSER. I would say there are a complex of factors. It would oversimplify it to indicate there is only one: I repeat: One can make more money if you are going to get into the fraud business in the larger urban areas than the medium-sized small ones. I think it is almost as simple as that.

Mr. DUNCAN. Should we just attack the problem then in New York City and see where we are headed?

Mr. GLASSER. In terms of priorities, certainly the major cities of the country—and New York is not the only city by a long shot. I think further investigation will indicate it isn't only New York and Chicago. I think there is no uniqueness about those two cities.

Certainly in terms of priorities from the Federal point of view, I would pick the larger cities, the 20 largest, or 30 largest in the country to concentrate on initially. I think that is where the principal problem is.

Mr. DUNCAN. Thank you very much.

Mr. ROSTENKOWSKI. Thank you, Mr. Glasser.

Mr. GLASSER. I appreciate the opportunity.

Mr. ROSTENKOWSKI. Dr. Bussman, welcome to the committee.

STATEMENT OF JOHN BUSSMAN, M.D., PRESIDENT, AMERICAN ASSOCIATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. BUSSMAN. Mr. Chairman, my name is Dr. John Bussman, I am a physician in the private practice of medicine in Portland, Oreg., and president of the American Association of Professional Standards Review Organizations.

The membership of our organization is composed of 123 PSRO's in various stages of implementation of the program. More than 110,000 physicians are direct members of our organization or are members of our PSRO constituent organizations.

As many of you know, we testified last September on legislation similar to that being considered today—proposals to deal with fraud and abuse under the medicare and medicaid programs.

As we indicated last year, we support the general thrust of the bill. It is an obvious and appropriate response to information developed by the committees in the Congress. The bill is designed to provide additional tools to combat fraud and abuse. We must express our belief, however, that these provisions, as well as those already in law, will not by themselves improve matters. Only an experienced, dedicated, and intelligent approach on the part of the various responsible organizations in the executive branch can yield good results.

With these general observations in mind, I would like to discuss briefly the PSRO provision of H.R. 3, introduced by the two distinguished chairmen of the subcommittees conducting this hearing.

The key provision is the proposed new subsection (g) of section 1155 of the Social Security Act. This new subsection would require the Secretary to give priority to any request of a PSRO to review the services furnished in a so-called medicaid mill, defined as a shared health facility in another section of the bill.

The remaining provisions of the bill are designed to enhance the ability of PSRO's to do a more effective job of dealing with abuse in the medicare and medicaid programs, including necessary support for those PSRO's which wish to tackle the job of reviewing medicaid mills.

For example, subsection (a) of section 5 would make clear that where a PSRO is found competent to review various health services, certain review and certification functions now required would no longer be necessary. As we read the proposed revision in section 1154(b), a PSRO could become fully qualified—that is no longer a conditional organization in a trial period—if it (1) were performing review of all hospital services, (2) it were reviewing other services for which the Secretary agreed it had developed the capacity, and (3) it had developed a plan for gradually assuming review responsibilities for other health services covered under medicare and medicaid. In addition, this section would make clear that a conditional PSRO in a trial period could have that status extended for an additional 2 years. We believe this is a sound approach.

One of the areas of the proposed legislation that concerns PSRO's around the country appears on page 19 of the bill as implying a mandate for the PSRO assume responsibility for the review of the ambulatory setting under a timetable to be established by the Secretary. We would submit that the technology to perform adequate ambulatory review is in its early stages and will require a considerable period of development and research before any widespread application could be expected to be feasible. The PSRO budget is not yet so generous as to afford nationwide ambulatory review when cost containment in acute care for long-term care facilities seems much more possible of accomplishment. Similarly, this subsection is subject to interpretation as deemphasizing the development of long-term care review and giving priority instead to ambulatory review.

We question whether the provisions in subsection (c) which would permit PSRO's to abstract, as well as examine, the medical records in the course of its work is necessary. The word "examine" in the present law would seem to us to encompass the ability to summarize that which is examined.

Subsection (d) of section 5 would also bring the reimbursement of PSRO's for their Government work in line with the system provided for other private organizations which contract to perform functions for the medicare program.

We also favor subsection (e) which would avoid duplication of various review functions by providing that the services for which a PSRO has been given review responsibilities by the Secretary will not be reviewed under any other mechanism, and that PSRO decisions on medical necessity and appropriateness of care will be binding on the paying agencies.

Subsections (f) and (g) make certain conforming changes and technical improvements in the law, and we agree they should be made.

Subsection (h) providing for regulation for implementation of a data policy has the potential for delay in establishing PSRO review and would almost certainly stifle the development and innovative data systems which might be more responsive to local circumstances.

Subsection (i) would require a PSRO to cooperate with recognized enforcement bodies investigating fraud under medicare and medicaid and to furnish aggregate statistical data to Federal or State ageincies for health planning related activities. We favor this provision — PSRO's are not policemen and we are glad to cooperate with those who are. However, we want to assure your committees, the Congress, and the public generally, that PSRO's, individually and collectively, are very concerned about confidentiality of the data we acquire. We are dedicated to the preservation of privacy of individual patient information. For example, the information on patients which we acquire would be made available to health planning and related organizations under these provisions only on an aggregate basis with no individual patient data.

Subsection (j) would require the Secretary of HEW to pay the costs of defending a suit brought against a PSRO, its members, employees, or professional consultants related to the performance of any duty or function required under the law. We should like to point out that carriers and intermediaries under the medicare program are completely protected against suits for their medicare work — the Government actually steps in and assumes the burden of defense and the liability risks.

We believe that another section of the bill which would require the contractual arrangements between fiscal intermediaries under medicare is pertinent here. If that provision were fully carried out, the Government would accept any suit filed against a PSRO based on its review of Government patients. The action would not lie against the Government agent, just as in the case of fiscal intermediaries. We believe that approach has a better result than this specific provision and would urge the committees to make that point clear in the report on the bill.

Although most of the PSRO's conducting review activities are now protected for liability through a private insurance carrier, if that protection were to be lost, we would encounter great difficulty in obtaining new coverage. It is important to note that the premiums for their insurance are paid for by the Government. Even a handful of suits which we would have to defend may jeopardize our ability to obtain insurance.

Subsection (k) assures that the lack of matching State medicaid funds will not result in a diminution of PSRO review activities. We favor the section.

Section (l) would require an annual report from the Secretary reporting on progress under the PSRO program. We favor this provision.

Subsection (m) and (n) would make necessary minor technical and conforming changes, and we favor them.

Mr. Chairman, our association believes in the proposition that effective and appropriate peer review is desirable for the care furnished to all patients, in all settings and by all health care providers. We do not believe that review should be limited to Government patients or just institutional care.

Many of our members, as well as members of our sister organization, the American Association of Foundations for Medical Care, are now engaged in the review of the care furnished to patients whose care is paid for by private third-party payors. Moreover, we have recently organized a national peer review network to arrange for such review services for multistate employers.

We are well aware that review services are not now available everywhere for all services, but we pledge our continued dedication to that objective.

Mr. Chairman, while the bill would no longer require the review of long-term care services before a PSRO could become fully operational, we favor the retention of that objective for all PSRO's and for active support from the Government to accomplish it. While HEW has approved several long-term care demonstration review programs, we urge that where PSRO's are ready to perform such review, where the necesary State and provider agreements have been made, that PSRO's be permitted to begin such review whether or not on a demonstration basis. Those PSRO's which have historically been involved in such review have reported good results with real improvement in patient care and substantial dollar savings. We believe the potential is great.

Mr. Chairman, we recommend that the program review team provisions of present law be repealed as no longer necessary and that PSRO's be allowed to perform the function of determining whether an individual practitioner or provider of services has grossly and flagrantly prescribed or provided unnecessary health care or care of poor quality. The present law assigns this responsibility to PSRO's but duplicates the functions in title XVIII, where teams established by the Secretary can perform this function.

We believe it is clearly preferable to have physician organizations performing peer review activities to make determinations and recommendations in this sensitive area. The PSRO does not want to act as a policeman. We view our role as one of determining areas of possible improvement in quality and cost control, both for individual physicians and the professional generally, through a variety of educational techniques. But we also believe that in those relatively few cases where individual determinations of this sort are required it should be the PSRO which makes them. We also urge the committees to add a provision to the bill to correct an apparent oversight in the original legislation.

While a State Professional Standard Review Council must perform certain functions under the law involving decisions on the need or appropriateness of care, it does not, as does the individual PSRO, have available to it the protection against liability now set forth in law. We urge the committee to correct this apparent oversight.

We feel PSRO review should be expanded to all patients. We realize there is no relationship between HEW and the Veterans Administration but we feel one should be established. We feel PSRO should be immediately expanded to VA hospitals.

Mr. Chairman, this completes our testimony. We thank you very much for the opportunity to present our views to you. We will try to answer any questions which members of the committees may have.

Mr. Rostenkowski. Thank you, Dr. Bussman.

Doctor, we have heard some opposition expressed to the provision in H.R. 3 that we would require PSRO's to undertake ambulatory care review. I was interested to note that your association endorses this provision.

As you know, this type of review is now optional for the PSRO's, and the argument has really been made that physicians would not accept the PSRO program if their out of hospital services were reviewed. Do you agree with that assessment?

Dr. BUSSMAN. I think it has taken us a long time to build significant physician support for the PSRO program, and I think this will pose some problems; yes. We agree that this should be the ultimate goal of the program, however, our chief concern as I expressed was that we appear to be deemphasizing long-term care review in favor of the emphasis on ambulatory review.

Mr. ROSTENKOWSKI. What are the problems that it would pose, Doctor?

Dr. BUSSMAN. Of ambulatory review? I don't think we have the technology. Our organization was one of the very first in the country — my local PSRO in Portland — organized to assume some responsibility for ambulatory review in the American programs experimental medical care organizations dating back to 1971.

We found just monumental problems in the technology. The only thing we have available that regularly flows from the physician's office to any review organization is a claim form; and the claim form is and of itself totally inadequate to address the question of quality; and so we are left with some means of identifying, probably through physician profiles, those physicians whose practice patterns are sufficiently out of keeping with the rest of the profession to arouse some suspicions that a further in-depth investigation was warranted; but at the present time those techniques are not really well-developed. I think we need a longer period of research. There are some six or eight PSRO's around the country who are presently participating in ambulatory review demonstration projects. Most of them involve voluntary physicians who want to do a little research study.

When we focus that on the everyday problems and make it a mandated review program that will apply to everyone in all settings, I just don think we are ready.

Mr. ROSTENKOWSKI. Mr. Rogers?

Mr. ROGERS. I believe the bill simply allows the Secretary to say whether the PSRO is capable of doing it.

Dr. BUSSMAN. We are just fearful we may be deemphasizing the important of long-term care, however, in favor of more rapid development of ambulatory review.

Mr. ROGERS. Another question: Should gross abuse that a PSRO may find be reported to the licensing authority of the State?

Dr. BUSSMAN. This is something I personally would favor. The present confidentiality requirements don't permit it. That will have to be further defined.

Mr. ROGERS. Thank you.

Mr. ROSTENKOWSKI. Mr. Duncan?

Mr. DUNCAN. Thank you, Mr. Chairman.

Did I understand you to say that the Federal Government pays the insurance premiums?

Dr. BUSSMAN. Yes.

Mr. DUNCAN. Who selects the insurance carrier?

Dr. BUSSMAN. It wasn't a matter of selecting an insurance carrier. Our organization met with — we had a meeting here in Washington at which eight national insurance carriers were to be present. We gave a party and nobody came. We scurried around for 3 months and found one carrier willing to assume this responsibility. That is Lexington Insurance Co. of Boston.

Mr. Duncan. Have you had losses?

Dr. Bussman. No losses.

Mr. Duncan. Do I understand that the contract is such that the insurance companies do not defend the lawsuit if you are involved in litagation?

Dr. Bussman. HEW—there is a deductible. HEW has agreed to pay the deductible. Then the insurance company defends and pays the judgment, if any.

Mr. Duncan. How much is the deductible?

Dr. Bussman. I think it's $2,500.

Mr. Duncan. Thank you.

Mr. Rostenkowski. Dr. Carter?

Mr. Carter. Thank you, Mr. Chairman.

What would you estimate to be the average cost per review insured health facilities?

Dr. Bussman. I really don't know. Iwould think most of the reviews in the insured health facilities—shared health facilities would not be predicted on a cost-per-patient reviewed, but I would think we would be talking about a project. When a shared health facility was felt to be at fault in regard to its compliance with the laws, it would be a team effort, a task force moving in to do review under those circumstances. This is the only thing that I can see as a feasible technique at the present time. To say it costs a dollar per patient visit to review would be a reasonable assumption; but that approach I don't think is the way it will really work.

Mr. Carter. You don't know if the $1 is correct or not?

Dr. Bussman. I know $1 is fairly close to what costs of ambulatory review have been in other settings.

Mr. Carter. What is the cost of such review compared with cost of PSRO review of hospital care?

Dr. Bussman. Hospital care review as you might imagine varies a good bit from one PSRO to another. We do have significant experience now; and the figures vary. I believe, from around $8 per hospital discharge on up to $15 or $16.

Mr. Carter. It costs that much to review one case on an average?

Dr. Bussman. Yes, sir.

Mr. Carter. How many PSRO's are now ready, in your view, to undertake review of shared health facilities?

Dr. Bussman. As we discussed last September this was to be optional and at the request of the PSRO. It is not so much a matter—it's truly a matter of readiness in many respects. My own personal feeling is there won't be many of them who want to be involved in this very difficult and unpalatable and potentially dangerous area of review.

Mr. Carter. OK.

Dr. Bussman. I understand one of them in New York is ready, anxious, willing, and able to assume this responsibility. I admire their courage.

Mr. Carter. I think you are right.

Thank you, Mr. Chairman.

Mr. Rostenkowski. Mr. Walgren.

Mr. Walgren. Just to sort of bring me along on this, what kind of dangers are they reluctant to get involved in in shared health reviews?

Dr. Bussman. They actually have been threatened with physical violence if they appear on the scene to do review, and some of the shared health facilities, we understand, have connections with organized—shall we say—crime that have made threats of violence to an organization that would become involved in this. The physician organization in one city has specified that one of the costs of the review process will include security to go with them.

Mr. Walgren. Would that be an area that perhaps the Secretary should do the reviews in rather than a peer organization?

Dr. Bushman. I think a peer organization can probably do a superior job of review if we can overcome some of these problems.

Mr. Walgren. That is all. Thank you.

Mr. Rostenkowski. Thank you, Doctor.

Dr. Bussman. Thank you.

Mr. Rostenkowski. Mr. Newman.

Welcome to the committee, Mr. Newman. If you will identify yourself and your organization?

STATEMENT OF HOWARD N. NEWMAN, PRESIDENT OF THE DARTMOUTH-HITCHCOCK MEDICAL CENTER, HANOVER, N.H.

Mr. Newman. Chairman Rostenkowski, Chairman Rogers, I appreciate having this opportunity to respond to your invitation to comment on the medicare-medicaid antifraud and abuse amendments, H.R. 3. As some members of this committee may recall, I served as the Commissioner of the Medical Services Administration in the Department of Health, Education, and Welfare from February 1970 through June 1974. Since that time, I have served as president of the Dartmouth-Hitchcock Medical Center, located in Hanover, N.H.

My professional experience in health administration in both the private and public sectors during the past 20 years, leads me to a strong and supportive view of H.R. 3. It is somewhat ironic, I think, that my first involvement with medicaid came almost 10 years ago when, during a year's attachment to the Director of the Bureau of the Budget, I participated in a task force charged with reviewing State estimating procedures in light of medicaid's early cost escalation.

My support of the bill before you is based on the view that it represents a step—and it is interesting that the previous witness spoke about it as a step, so I am a member of the only a step school—and not an unimportant step, toward achieving greater credibility for the medicaid program among providers, recipients, and the public at large. Of the specifies contained in this bill, I would support most emphatically those sections dealing with the requirements of disclosure of ownership and financial information. As a result of my personal experience with the medicaid program, I have long supported the desirability of extending and enforcing disclosure requirements based on a rationale that the glare of sunlight is an effective deterrent to improper conduct by both administrative agencies and providers, I should also like to express my support of section 10 of the bill, claims processing and information retrieval systems for medicaid programs, which, although perhaps viewed by some as only a technicality, will allow for substantially more efficient application of state of the art systems capability in medicaid.

If there is one fact about medicaid on which everyone can agree, it is that it is an enormously complex undertaking. That complexity, however, can mask the frequently conflicting objectives and subobjectives of the administrative and programmatic elements of the program. Equity of access to services and cost containment are probably the most obvious of these potentially conflicting value systems. The roles of the Federal Government, the States, health care providers, and even recipients, all contain inherent potential conflict. Thus we have seen the medicaid program achieve a kind of equilibrium in which the kinds of problems which the bill before your attempts to remedy have become relatively common.

I have said that this bill represents a step in the right direction. I should like to emphasize that the direction should involve a substantial restructuring of the medicaid program and, in fact, a complete overhaul of our health financing programs. It is probably correct, however, that until there is greater confidence in the capacity of the Federal Government to respond to what are perceived as the immediate issues such as those addressed in H.R. 3, such overhaul cannot take place.

When one takes a look at the slightly broader medicaid horizon, I believe the following conclusions can be substained as the major lessons of the medicaid experience:

One: Financing health care for the poor must be accomplished in the context of broader, probably universal, solutions to the problems of health financing. A health program designed specifically for the poor will be a poor program.

Two: Only if incentives within the health delivery system itself are developed can we achieve an equitable and efficient result from our health financing programs. Absent such incentives for more rational organization of the health care system, the inflationary result experienced in recent years is virtualy inevitable.

Three: Emphasis in the design of future health financing programs should be placed on preventive health services for children and effective means of outreach must be built into such programs.

Four: For the elderly, especially, the integration of health and social services at the local level must be encoruaged through the removal of financial incentives to institutionalize people.

Five: The consequences of operating medicaid within the Federal welfare establishment, SRS, are inherently in conflict with the program's goals. The solution, I believe, lies in the creation within HEW of an independent health financing agency.

I am mindful of the admonition contained in the announcement of these hearings that national health insurance is not the subject under discussion. It is, nonetheless, important to recognize that the underlying issues of management toward which H.R. 3 addresses itself are generic to all health financing programs and most particularly, those which are publicly supported. It is for that reason that I should like to conclude these brief remarks by stating that only through (1) the exercise of leadership in defining national policy objectives, (2) the development of a strategy involving public and private enterprise to achieve those objectives, and (3) the establishment of management capacity which provides incentives for accomplishing those objectives in an efficient, yet compassionate manner, consistent with available resources and with a realistic understanding of the operation of the health care field, can the proper Federal role, even in the context of a universal and mandatory health financing program, be achieved.

Thank you very much.

Mr. ROGERS [presiding]. Thank you very much, Mr. Newman, for your statement.

Mr. Walgren?

Mr. WALGREN. I have no questions.

Mr. ROGERS. Let me just ask this: what do you think of the proposition of having all institutional providers being required to have a uniform accounting system?

Mr. NEWMAN. My sense is that this is a complicated issue and technically more difficult than may appear on the surface.

I am aware of the heavy reporting requirements that people in hospitals complain about. I am also aware there is great variation in kinds and types of hospitals in this country. My general impression, nonetheless, is that in principle your position is sound. It seems consistent with the notion that we are attempting to develop a rational planning system in this country for health services and that in that context, it makes emiment good sense.

I have had an opportunity to review briefly the bill that Mr. Moss and you have introduced; and I am impressed by the acknowledgment in section 2 of the bill that the secretary would be obliged to consult with interested parties including organizations which represent health service institutions. I think that would be important. The principle seems to me quite sound.

Mr. ROGERS. What do you think of the idea of allowing a person on medicaid to choose a doctor but not getting other services, unless that doctor recommended it?

Mr. NEWMAN. My general reaction to suggestions of this kind is if that seems like a reasonable course to pursue for the rest of the population, it would be reasonable to do it for the medicaid recipient.

Mr. ROGERS. I think the point is that most people do that.

Mr. NEWMAN. To the extent that the idea is that one would have a primary care physician who serves as the focal point of his services, that seems reasonable. On the other hand, one would have to be careful if the result was a limitation of access which is already severely limited in the medicaid population.

Mr. ROGERS. Thank you.

Mr. Carter?

Mr. Carter. Thank you, Mr. Chairman.

I regret that I was out part of the time. The part of your testimony that I have been able to read seems to be all right, very good. It is a pleasure to have you here.

Mr. Newman. Thank you very much.

Mr. Rogers. Thank you very much. The committee is grateful for your presence here today.

The next witness is David L. Rosenbloom, the commissioner, Boston, Mass., Department of Health and Hospitals.

STATEMENT OF DAVID ROSENBLOOM, COMMISSIONER OF HEALTH AND HOSPITALS, BOSTON, MASS.

Mr. Rogers. Welcome to the committee. Your statement will be made a part of the record. I should say I may have to interrupt you. There is a vote. You may proceed until we have to go.

Mr. Rosenbloom. Let me summarize the remarks that I have submitted to the committee. I appreciate the opportunity to be here today.

I know your committee is concerned about fraud and abuse and that it grows in part from its effort to contain costs in the medicare and medicaid programs. Cost containment is an important effort, because until it shows results, it will be difficult to move toward a decent national health insurance program. However, most of the efforts in the name of cost containment which have been made so far have merely shifted the costs of medical care for the poor back to the cities and counties or eliminated services which people needed.

Cost containment is one thing, but passing the buck is another. For example, in Massachusetts until December 1, 1975, medical assistance was available to a broad range of poor people. Now the program of medical assistance for those on general relief has been ended. As a result, more than 30 percent of the patients we see at Boston City Hospital no longer have any State or Federal medical assistance. This year the city of Boston taxpayers will provide at its expense between $10–$12 million of service that would have been paid for under State and Federal programs 2 years ago. Despite this, the State's total expenditures for medical care for the poor will be $100 million larger than they were when these programs were ended.

We believe we have developed a delivery system which is relatively free of fraud and abuse, is responsive to people's needs and contains costs. W shall serve more people this year for $5 million less than we spent last year. However, because of the money drained away from the public by fraud and abuse — both legal and illegal, and because of the inflation built into medicare and medicaid, the very existence of our delivery system is threatened.

The current organization and operation of the medicaid program is a direct cause of the fiscal crisis which is threatening to destroy the publicly-operated health care delivery systems in our major cities. The fraud and abuse which we are talking about today is an inherent part of the organization and operation of our current system. While increased regulation and fines will help, they alone will not face the root issue.

Under medicare and medicaid hospitals and doctors are cost-plus businesses. The law provides they will be reimbursed their usual and customary costs for providing services to individuals who were entitled to benefits. As long as the basic structure of the program is to pay individual providers for whatever they do to individual patients when they do it, we shall have a medicaid and medicare system that is prone to abuse and too expensive. No amount of regulatory threat will be able to overcome the incentives contained in the reality that more work on a patient means more money for the provider.

Hospitals and other providers can get around whatever regulations are imposed by the State and Federal Governments. Let me give you one dramatic and current example. Massachusetts passed new cost control legislation last year. One major hospital, I am told, has found is charges to the State and patients to be so far above its actual cost that it is about to give everyone who works for the hospital a raise rather than lower its charges. The inflation and abuse has been built in by the design of the program.

Beyond the inherent problem of inflation contained in the program, Mr. Chairman, one of the reasons fraud and abuse has become commonplace in the medicaid programs if the administrative quagmire in which these programs operate. I do not need to regale you with the horror stories of how medicaid actually operations. It is enough to say it doesn't work. Almost one-third of the legitimate bill submitted by our system fail to get paid the first time they go through the system. It does not work for the patient who must go through a demeaning and lengthy process to become eligible. It does not work for the provider of services who deliver the service and then steer the patient through the welfare application process. It does not work for the State because it cannot control its cost or administer the program. It does not work for the Federal Government because it is the victim of all the financial abuse resulting from administrative waste.

It does not work for the taxpayers of the city of Boston because they wind up front-ending and ultimately paying for a substantial amount of care which should be paid for by medicaid but is not because the medicaid system simply is incapable of identifying eligibile recipients and promptly paying bills. Almost one-third of our legitimate bills fail to get through to payment the first time they are submitted. We are currently in a dispute with the State over more than $3 million of bills for fiscal year 1975, which ended 18 months ago.

Mr. Chairman, one of the things H.R. 3 attempts to outlaw is factoring medicaid bills through a middleman. I am sure that is a desirable approach to limiting financial abuse. However, it is my understanding that factoring came into wide use early in the program when it became clear that local and State governments simply could not process legitimate bills in anything approaching reasonable time. While some progress from the early years has been made, anyone who tells you that medicaid is a well-run program has never tried to get a medicaid bill paid.

Perhaps I am just simple-minded, Mr. Chairman, but I believe that a system which is as complicated and cumbersome in its administrative procedure as medicaid, must be prone to fraud. I have been impressed by the argument that the Veterans Administration hospitals, which are generally regarded as cost effective, provide services to veterans without complex or demeaning tests and regulation. Yet, there seems to be no outcry that the systems are overused and abused. My hedonistic learnings tell me that too much of a good thing is probably a good thing, but that may not be true in regulation. Overregulation may help create some of the fraud which we are here today complaining about. Simplifying the program may well eliminate many of the opportunities for fraud.

Mr. Chairman, the bills seeks to display for public view the owners of health care facilities. I believe this is an appropriate matter of concern because the organization in which care is delivered is crucial to both the quality and cost of the treatment. Some of the most notorious abuses in medicaid and medicare have occurred in private profit-making medicaid mills. There is no public accountability for what they do to individual patients and nursing homes.

On the other hand where there are genuinely community-based and controlled nonprofit neighborhood health centers the board can look responsibly at what providers are doing. They can be held accountable for the performance of health professionals. There is no special sanctity in a community-based group and there have been problems, but they are controlled by people who can be gotten to by their friends and neighbors.

Often, the priorities set by the neighborhood group can lead to lower costs for medical care because they have less of an interest, financially or emotionally, in enhancing medical institutions. Let me give you a concrete example:

When the East Boston Neighborhood Health Center was formed, the neighborhood board said its highest priority was the development of a long-time nursing and medical care program which would allow older people to remain at home during their final days. The people of East Boston resented the trend toward long-term hospitalization or nursing home cusodial care. However, there were no alternatives available in their community to help people remain at home. They demanded and got such a program. And it is substantially cheaper than placing people in long-term care institutions to which neither they nor their families wanted to go.

Another of our neighborhood health center boards set improved prenatal care as its highest objective. We have concentrated in developing these programs in that neighborhood. The result is a halving of the infant death rate in the area served by that health center. And, when mothers go to the hospital to have their babies they now stay less than half the amount of time they stayed 3 years ago because they are healthier and better prepared for their birth experience than they used to be. Their babies, too, are healthier so they require less intensive hospital treatment after birth. In short, Mr. Chairman, the desires of these community boards for high quality have also led to controlling the cost of care. It is a lesson which should not be lost as we take a positive approach to eliminating fraud and abuse in medicaid and medicare.

Mr. Chairman, the bill you have before you placed additional emphasis on PSRO or quality review activities. The approach attempts to guarantee quality by regulation while the financial incentives will still all work against that. A more positive approach to controlling fraud and abuse would be to place the providers of health care at risk for insuring both quality and appropriate use of health care by making them publicly accountable and financially liable for controlling costs. I do not mean to be overly critical of PSRO activities. It is just that a financial incentive which force providers to limit their costs would be much more effective. That is one reason responsible prepaid mechinisms have been shown to be less expensive than fee for service systems.

In the neighborhood health centers, the providers are held accountable for controlling their costs because they operate on an annual budget that is determined in advance. That budget is based in part on the number of people they see, but also on the services they provide according to a set of standards. Since everyone in the center is salaried there is no incentive to see more and more patients or do more and more tests. Yet, the management and board can enforce standards of productivity.

I said at the beginning of my remarks the health care system we tried to build in Boston and in other cities based upon neighborhood health centers with central hospitals are probably the best existing alternatives to fraud and abuse in our major cities. I am here to tell you today that that alternative is going broke. If we are unable to continue financing the health care system we have developed in Boston, health care costs are going to rise rather than decrease.

I know, Mr. Chairman, there is a reluctance to do much at the Federal level this year other than legislate against fraud and abuse while the study of comprehensive health insurance goes on. Given the unbridled inflation which has occurred in the health care industry I understand your reluctance.

However, the inflation has been caused by medicaid and medicare and it is threatening to destroy public delivery systems which have been built in several of our major cities. If these systems go under waiting for national health insurance your succesors and mine will be here 12 to 15 years from now wondering how health care costs can be kept to less than 25 percent of the gross national product.

In summary, Mr. Chairman, I hope your committee will deal affirmatively with the issue of fraud and abuse in medicaid and medicare programs. I hope you will expand the proposal you now have to be sure that systems which check fraud and abuse survive. I hope you will act affirmatively to strengthen those Federal programs which now exist to support neighborhood health centers and publicly accountable local systems which control the quality of care they provide.

And, Mr. Chairman, I hope you will support efforts to control the rising costs of health care by putting the providers at risk for containing their own costs. Only in this way, Mr. Chairman, will it be possible for the Congress, the State and local governments to work together to fulfill their promise to the legislative health needs of our poor and our elderly citizens.

In my written statement I suggested a variety of steps which might be taken under existing law by this committee to move toward meeting these objectives. I think it is unnecessary to repeat them here.

[The prepared statement follows:]

STATEMENT OF DAVID ROSENBLOOM, COMMISSIONER OF HEALTH AND HOSPITALS, BOSTON, MASS.

Thank you Mr. Chairman, I am David Rosenbloom, the Commissioner of Health and Hospitals for the City of Boston. Thank you for the opportunity to appear today.

Many of our large cities are in financial trouble and a major reason is the amount of money they must spend providing health care services to the poor and the elderly. For example the City of Boston owns and operates one of the most complete health delivery systems in the nation. It is based on neighborhood health centers funded in part by the city. Each center is governed by local citizen board. Additionally, the City operates a 500 bed teaching hospital which provides a quarter of the City's total emergency service and more than a third of its outpatient services. We maintain a home care program in various neighborhoods and two chronic care hospitals. Me operate the ambulance system. We sponsor medical, nursing and allied health training and house some of the nation's finest medical research facilities.

I know Mr. Chairman that your concern about fraud and abuse is part of an effort to contain the costs of medicare and medicaid. This is a very important effort because until it shows results it will be difficult to move to a decent national health insurance program. However, most of the efforts in the name of cost containment which have been made so far have merely shifted the costs of medical care for the poor back to the cities and counties or eliminated services people need. That approach, Mr. Chairman simply must come to an end. Cost containment is one thing passing the buck is another. For example in Massachusetts until December 1, 1975 medical assistance was available to a broad range of poor people. Now the program of medical assistance for those on general relief has been ended. As a result, more than 30% of the patients we see at Boston City Hospital no longer have any state or federal medical assistance. This year the City of Boston taxpayers will provide at its expense between $10–12 million of services that would have been paid for under the state and federal programs two years ago. Despite this the state's total expenditures for medical care for the poor will be $100 million larger than they were when these programs were ended.

We believe we have developed a delivery system which is relatively free of fraud and abuse, is responsive to peoples needs and contains costs — we shall serve more people this year for $5 million less than we spent last year. However, because of the money drained away from the public by fraud and abuse — both legal and illegal and because of the inflation built into medicare and medicaid the very existence of our delivery system is threatened.

The current organization and operation of the medicare and medicaid program is a direct cause of the fiscal crisis which is threatening to destroy the publicly operated health care delivery systems in our major cities. The fraud and abuse which we are talking about today is an inherent part of the organization and operation of our current system. While increased regulation and fines will help, they alone will not face the root issue.

Under medicare and medicaid hospitals and doctors are "cost-plus" businesses. The law provides they will be reimbursed their usual and customary costs for providing services to individuals who were entitled to benefits. The result has been an unbridled inflation.

Under the current system every patient is literally a potential gold mind. The more veins that can be mined the more money that can be extracted. No one should be surprised that more and more things are done to people for higher and higher prices.

As long as the basic structure of the program is to pay individual providers for whatever they do to individual patients, when they do it, we shall have a medicaid and medicare system that is prone to abuse and too expensive. No amount of regulatory threat will be able to overcome the incentives contained in the reality that more work on a patient means more money for the provider.

Hospitals and other providers can get around whatever regulations are imposed by the state and federal governments. Let me give you one dramatic and current example. Massachusetts passed new cost control legislation last year. One major hospital, I am told, has found its charges to the state and patients to be so far above its actual costs that it is about to give everyone who works for the hospital a raise rather than lower its charges. The inflation and abuse has been built in by the design of the program.

Beyond the inherant problem, Mr. Chairman, one of the reasons fraud and abuse has become commonplace in the medicaid programs is the administrative quagmire in which these programs operate. I do not need to regale you with the horror stories of how medicaid actually operates. It is enough to say it doesn't work. It does not work for the patient who must go through a demeaning and lengthy process to become eligible. It does not work for the provider of services who deliver the service and then steer the patient through the welfare application process. It does not work for the state because it cannot control its cost or administer the program. It does not work for the federal government because it is the victim of all of the financial abuse resulting from administrative waste.

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Mr. Chairman one of the things H.R. 3 attempts to outlaw is factoring medicaid bills through a middle man. I am sure that is a desirable approach to limiting financial abuse. However, it is my understanding that factoring came into wide use early in the program when it became clear that local and state governments simply could not process legitimate bills in anything approaching reasonable time. While some progress from the early years has been made, anyone who tells you that medicaid is a well run program has never tried to get a medicaid bill paid.

Perhaps I am just simple minded Mr. Chairman but I believe that a system which is as complicated and cumbersome in its administrative procedure as medicaid must be prone to fraud. I have been impressed by the argument that the veterans administration hospitals, which are generally regarded as cost effective, provide services to veterans without complex or demeaning tests and regulations. Yet, there seems to be no outcry that the systems are overused and abused. My hedonistic leanings tell me that too much of a good thing is probably a good thing but that may not be true in regulation. Over regulation may help create some of the fraud which we are here today complaining about. Simplifying the program may well eliminate many of the opportunities for fraud.

Mr. Chairman, your bill seeks to display for public view the owners of health care facilities. I believe this is an appropriate matter of concern because the organization in which care is delivered is crucial to both the quality and the cost of the treatment. Some of the most notorious abuses in medicaid and medicare have occurred in private profit making "medicaid mills." There is no public accountability for what they do to individual patients and nursing homes.

On the other hand where there are genuinely community based and controlled non-profit neighborhood health centers and board can look responsibly at what providers are doing. They can be held accountable for the performance of health professionals. There is no special sanctity in a community based group and there have been problems, but they are controlled by people who can be "gotten to" by their friends and neighbors.

Often, the priorities set by the neighborhood group can lead to lower costs for medical care because they have less of an interest, financially or emotionally, in enhancing medical institutions. Let me give you a concrete example.

When the East Boston Neighborhood Health Center was formed the neighborhood board said its highest priority was the development of a long term nuring and medical care program which would allow older people to remain at home during their final days. The people of East Boston resented the trend toward long term hospitalization or nursing home custodial care. However, there were no alternatives available in their community to help people remain at home. They demanded and got such a program. And, it is substantially cheaper than placing people in long term care institutioni to which neither they nor their families wanted to go.

Another of our Neighborhood Health Center boards set improved prenatal care as its highest objective. We have concentrated in developing these programs in that neighborhood. The result is a halving of the infant death rate in the area served by that health center. And, when mothers go to the hospital to have their babies they now stay less than half the amount of time they stayed three years ago because they are healthier and better prepared for their birth experience than they used to be. Their babies, too, are healthier so they require less intensive hospital treatment after birth. In short, Mr. Chairman, the desires of these community boards for high quality have also led to controlling the cost of care. It is a lesson which should not be lost as we take a positive approach to eliminating fraud and abuse in medicaid and medicare.

Mr. Chairman the bill you have before you places additional emphasis on PSRO or quality review activities. The approach attempts to guarantee quality by regulation while the financial incentives will still all work against that. A more positive approach to controlling fraud and abuse would be to place the providers of health care at risk for insuring both quality and appropriate use of health care by making them publicly accountable and financially liable for controlling costs. I do not mean to be overly critical of PSRO activities. It is just that a financial incentive which forces providers to limit their costs would be much more effective. That is one reason responsible prepaid mechanism have been shown to be less expensive than fee for service systems.

In the Neighborhood Health Centers, the providers are held accountable for controlling their costs because they operate on an annual budget that is determined in advance. That budget is based in part on the number of people they see but also on the services they provide according to a set of standards. Since everyone in the center is salaried there is no incentive to see core and more patients or do more and more tests. Yet, the management and board can enforce standards of productivity.

Mr. Chairman I believe the Carter administration proposal to put a cap on hospital prices is a step toward making providers responsible for the total cost of their activities. I believe that further steps in that direction will be far more successful in reducing abuse and overuse of health care than regulatory checks such as PSRO.

Mr. Chairman I am sure that you have heard from many people that ambulatory care based outside a hospital is cheaper than hospital based care. That point has been demonstrated again and again in our neighborhood health center system. (Of course, there have been some notable failures in the Neighborhood Health Center movement in which costs per visit have been much higher than at hospitals. But that have been the exception rather than the rule.) The federal government has been helpful, in a limited degree, in promoting the development of the Neighborhood Health Centers. However, as money tightens up in medicaid and medicare and as state government cuts off programs, the viability of Neighborhood Health Centers is materially threatened.

In short Mr. Chairman, I am here today to tell you that the best existing alternative to fraud and abuse in our major cities is going broke. And, in Boston if we are unable to continue — financing the health care system we have developed costs will increase not decrease.

I know Mr. Chairman there is a reluctance to do much at the federal level this year other than legislate against fraud and abuse while the study of comprehensive health insurance goes on. Given the unbridled inflation which has occurred in the health care industry I understand your reluctance.

However, the inflation has been caused by medicaid and medicare and it is threatening to destroy public delivery systems which have been built in several of our major cities. If these systems go under waiting for national health insurance your successors and mine will be here 12–15 years from now wondering how health care costs can be kept to less than 25% of the gross national product.

In summary Mr. Chairman I hope your committee will deal affirmatively with the issue of fraud and abuse in medicaid and medicare programs. I hope you will expand the proposal you now have to be sure that systems which check fraud and abuse survive. I hope you will act affirmatively to strengthen those federal programs which now exist to support Neighborhood Health Centers and publically accountable local systems which control the quality of the care they provide. And Mr. Chairman I hope you will support efforts to control the rising costs of health care by putting the providers at risk for containing their own costs. Only in this way Mr. Chairman will it be possible for the Congress, the state and the local governments to work together to fulfill their promise to the legitimate health needs of our poor and our elderly citizens. Listed below, Mr. Chairman, are specific steps the federal government could take now to achieve these goals:

1. USE THE POWER CONTAINED IN SECTION 1115 OF THE SOCIAL SECURITY ACT

This section enables the Secretary to waive virtually all of the restrictive medicaid requirements in order to carry out a demonstration program which will meet the goals of the act. This provision could be used to develop a city-wide demonstration program emphasizing out of hospital primary care and hospital trauma room emergency activity. It could be used to relieve cities and states' from the burden of getting each and every poor person they serve through the whole welfare application system. It could also be used to develop a prepaid plan to cover the poor in a few cities that put the providers at risk for containing costs and ensuring quality. In short, this section, coupled with some new money and ingenuity could solve the short term problems of many major cities.

2. FUND SECTION 330 OF PUBLIC LAW 94–63

This section enables neighborhood health centers to pay the hospital costs of patients who have no other coverage. If sufficient funding was available through this mechanism we could direct increasing ambulatory activity into the neighborhood health centers where it belongs. We have found in Boston that hospitalization rates from the NHC are substantially lower than hospitalization rates from either private practitioners or hospital based out-patient departments. A program funded under this section would be a dramatic demonstration of how the future should be designed.

3. CHANNEL THIS YEAR'S INTERN AND RESIDENT TRAINING MONEY, AVAILABLE THROUGH THE NEW FEDERAL MANPOWER ACT, TO MEDICAL SCHOOLS SERVICE CENTER CITY HOSPITALS

There is $10 million appropriated. The major municipal hospitals carry a disproportionate burden of training future doctors. This inequity could be balanced quickly if the new manpower training money were concentrated in central city municipal hospitals in a way that allowed them to transfer some of their costs. Hospitals like Boston City are really national training resources. Municipal hospitals in central cities train about 40% of all interns and residents in the nation. If the federal government is not going to pay for the care of the poor directly in the short run the least it can do is pay indirectly by supporting residents and interns in municipal institutions.

4. WAIVE MAINTENANCE OF EFFORT FOR CETA PROGRAMS WHEN CETA EMPLOYEES ARE USED IN HEALTH CARE INSTITUTIONS

Under the current manpower legislation a city or local government must maintain its current level of employment before it can use any CETA resources to hire people. When this rule is strictly applied it negates the potential help CETA can be in relieving local pressures and also limits our capacity to create new jobs. If this requirement could be waived. we could develop programs to provide substantial numbers of new jobs as well as supplement our own ability to keep people currently employed on the job. For example, we are about to start a CETA training program using Title I money (where there is no maintenance of effort requirement) that will train and provide jobs for approximately 200 new people a year. We and others could have similar programs under Title II and VI that would create new jobs, expand or at least maintain services for the poor in the cities and relieve the city treasury.

5. EXPAND THE MATERNAL AND CHILD CARE PROGRAMS NOW SPONSORED BY HEW

In central cities like Boston these programs have a demonstrated effectiveness. In areas where our neighborhood health centers are running maternal and child care programs we have literally halved the infant death rate in the last eight years. These funds are now threatened in Boston and other cities because the federal government is pressuring the state governments to spread the money around more without any increase in the appropriation. Thus, money which had been coming to Boston will soon be shifted to other parts of that state. That is simply crazy.

6. EXPAND FUNDING AVAILABLE UNDER SECTION 16–25 OF PUBLIC LAW 93–641

This program provides grants to municipal hospitals to replace sub-standard facilities. One of the major reasons our costs are high is the outdated nature of our physical plant. Like most old city hospitals, BCH is a collection of antique inefficient buildings. If we were able to consolidate our physical plant we could cut our operating costs by several million dollars a year. The state and federal governments would share in this savings because our reimbursement rates would be lower. Boston has applied for $6.2 million under this program. Applications for other cities total in excess of $80 million. Unfortunately there is only $11.5 million in the pot at the moment. Since each project is ready to go, increasing funding to this pot would be a quick and effective way to move money into the cities for public works jobs and at the same time reduce or contain future expenditures for care.

7. PROVIDE SERIOUS DEMONSTRATION MONEY FOR NON-INSTITUTIONAL APPROACHES TO LONG-TERM CARE

Long term care now absorbs more than half the medicaid budget in Massachusetts and is growing in virtually every other state. Through two of our own neighborhood health centers we have developed models utilizing nurse practionners backed up by doctors to provide long term home care to patients who would previously have been institutionalized. For many patients this is a superior and less expensive approach. We need to have some large and dramatic demonstrations about these alternatives that intergrate elderly housing with para professional medical and social care. As the population ages and as chronic disease becomes more important, a solution to this problem is going to become more and more urgent.

The Commonwealth of Massachusetts first priority for relief from medicaid costs is to have the federal government take over the cost of long term care. If I were confident the state would use the money to pay for the costs of caring for poor I would be delighted with this approach. However, unless there is a demonstrated capability to provide alternatives to institutionalization federalizing long term care will only add to its costs.

8. CHANGE THE MEDICAID REIMBURSEMENT FORMULAS TO ABSORB BAD DEBT AS A WHOLE RATHER THAN JUST BAD DEBT ASSOCIATED WITH THOSE PROGRAMS

This may turn out to be a fast and relatively inexpensive way of solving the problems of the major municipal hospitals. The bad debt at most other hospitals is absorbed in Blue Cross rate. Since the municipals have such a small percentage of Blue Cross they have no where to pass off the bad debt from those who have no coverage. If medicaid and medicare formulas could be adjusted to absorb the bad debt you could solve a major portion of the municipals problems without generating a major political debate about expanding coverage to new groups. If this were the only thing to be done costs would increase. However, if it were a short term measure accompanied by other reforms it might help.

9. FEDERALIZED MEDICAID

This is a very attractive option to the states. It would get them out of the business. However, we now have more patients in our system who have no medicaid coverage than who do. The same is increasingly true in other major cities. A simple federalization of the current medicaid program would do nothing more than add to the federal governments costs. It would not address any of the delivery issues.

10. INCREASE FUNDS AVAILABLE TO HEALTH CENTERS

The high cost of some OEO funded health centers has given the movement a black eye. Most of the health centers we operate see patients at less than half the cost of our out-patient department. An expansion of funds earmarked for health centers through municipal delivery systems could preserve our ability to fund these cost effective programs. Since the impact of these health centers on preventing fraud and medical abuses on lowering infant mortality and a lowered rate of hospitalization has been so dramatic it would be an appropriate way to support health care in the inner cities. At the moment we are trying to sustain our effort in this area. Other cities are trying as well. However, as the losses from the emergency services and inpatient services continue to mount our ability to sustain this commitment is becoming more and more strained.

11. SUPPORT A NATIONAL BUDGET CAP ON HOSPITAL INCREASES

This is a very controversial matter and the state's attempt to do this has just been set aside by Judge Garrity. However, the federal government could change its rules. The simple truth is that as long as the voluntary sector is out to raise its rates there will be less and less money available to pay the costs for the poor. It is the position of the American Hospital Association and the hospitals it represents that they must be reimbursed the full cost of care they delivery even if that means cutting entire groups of people off from eligibility. Until some effective cap is placed on what they can spend and incentives built in for them to control expenditures, they will continue to drain more and more away. A total budget cap would be arbitrary and difficult to enforce or sustain over the long haul. However it would break the ice toward a new system.

Thank you Mr. Chairman.

Mr. Rostenkowski [presiding]. Thank you, Mr. Rosenbloom.

Mrs. Keys?

Mrs. Keys. No questions.

Thank you very much.

Mr. Rostenkowski. Dr. Olch.

Welcome to the committee, Doctor. If you will identify yourself and your association, you may proceed.

STATEMENT OF DAVID OLCH, M.D., ON BEHALF OF THE CALIFORNIA MEDICAL ASSOCIATION

Dr. Olch. Thank you.

Mr. Chairman, members of the subcommittee, I am David Olch, a full-time private practitioner of internal medicine in Los Angeles. I am also a senior medical consultant to Occidental Life for Medicare, Part B. I am here today representing the California Medical Association.

We appreciate the opportunity of presenting this testimony. We are against fraud and abuse of any program. I have been involved in fraud and abuse control for the past 10 years with medicare. We commend you for your efforts to find ways to further eliminate fraud and abuse in the federally-funded medical programs.

We support section 4 of the bill which increases the penalty for defrauding the medicare and medicaid programs from a misdemeanor to a felony. We support the concept of shutting down the so-called medicaid mills or any other type of practice which involves fraud, intentional abuse of the programs and the delivery of substandard or dangerous or unnecessary medical care.

We are of the opinion, however, that the mechanisms exist for doing this without, establishing the elaborate reporting system contemplated by H.R. 3, with the additional involvement of the PSRO's by amendments. Carrier and intermediary procedures based on computerized claims screening devices all ready identify problem areas which require additional investigation and review by practicing physicians who know the standards of practice in the community. The volume of a physician's or clinic's practice is known, the type of services provided compared with other physicians of the same specialty in the same geographical area are known. Prescribing patterns and institutional use patterns are known.

Fraud and abuse control is a necessary byproduct of the assurance of proper reimbursement under the medicare program.

In California, independent medical consultants employed by carriers and intermediaries review the case material which is identified. When a pattern of possible fraud is documented and investigated extensively under program integrity and verified, the facts are referred immediately to the regional office of the BHI for investigation.

When a pattern of possible abuse or care which is below standard is identified, the facts are referred to the local county medical society or medical review committee or foundation for medical for review, evaluation, and where appropriate, education of the physician regarding the usual standards of practice in the community. When this type of peer review does not correct the situation, recommendations for suspension from the program have been transmitted to the appropriate Federal and State agencies.

This is the point where frustration with the current system sets in. State and Federal governmental agencies have been totally ineffective in suspending physicians and other providers from the programs. For example, during the period from 1967 through September, 1976, California Blue Shield, part B, medicare carrier for Northern California and medicaid intermediary (in partnership with the two Blue Cross plans) referred 356 cases to Bureau of Health Insurance and 412 to medicaid State agencies.

Of these, only 46 were for possible suspension and only two providers were suspended. Occidental Life Insurance investigated 1,994 provider cases during the period 1970 to 1976, and of those, 398 were turned over to the Bureau of Health Insurance for investigation, with only seven convictions.

California's medicaid program has for years had the legal authority to suspend a physician from the program for providing services which are below or which are clearly in excess of accepted standards of practice.

Medicare has similar authority, however, the program review teams which will implement this section of the law were not named in California until a month ago.

We feel that the existing programs should be fully implemented and supported before new concepts are legislated. We do not see how H.R. 3 will correct the problem of lack of prosecution of known offenders. Requiring detailed financial interest cost and income information from virtually all of the physicians in the country is a waste of time and money and will put an unreasonable burden on the vast majority of honest and ethical physicians in this country. It would escalate the cost of claims processing beyond affordable levels and the costs would be disproportionate to the amount of cost control gained and the number of fraud cases uncovered.

The new definition of a "shared health facility" serves no legitimate purpose other than to subject physicians who are sharing health facilities to detailed disclosure at the discretion of the Secretary of HEW or of the Comtroller General. There is no effective way that the governmental agencies can make use of the amassed information which would be received in a confidential or fair way without violating confidentiality. This approach would place the physician's community in a defensive position with respect to a vast bureaucracy, especially when only two physicians are involved in sharing space. Based on my own personal experience as a senior medical consultant for Occidental Life Insurance, the majority of physicians of the part B medicare program have attempted to provide good quality medical care and should be encouraged to continue to do so.

Those individual physicians who do not follow the established pattern of care have always been easily identifiable but difficult to prosecute—and this is where we need possible legislative assistance.

The U.S. attorneys are reluctant to undertake prosecution and indictment because of the problems involved in due process.

I would like to close with a word of caution. The volume of a physician's or clinic's practice does not correlate with incidences of fraud and abuse. Large volume practice frequently does provide effective and high quality care. Just because a physician or group of physicians see a high volume of medicare and medicaid patients is not sufficient reason to imply that they are defrauding or abusing the program. Often under the reporting system only the name of the senior man in a group is used. There is sufficient information being gathered by carriers and intermediaries to identify aberrant patterns of practice, regardless of the type of practice or business arrangements between physicians currently being utilized.

Therefore, we recommend, (1) that your staff carefully analyze current law and regulations so that you will be able to build on existing authority; (2) that you study the information available in existing files and through existing systems for background clarification; (3) that you talk with carriers, intermediaries and BHI program integrity people in States with active fraud and abuse detection programs to see what help they need to prosecute and suspend from participation known offenders.

This, coupled with increasing the severity of penalties will represent a major step forward. Effective and timely prosecution of offenders is the best deterrent to fraud and intentional abuse by individuals who place personal gain above integrity and the well-being of the community.

I honestly do not feel putting the PSRO's in the physician's office will identify more fraud than we already find by the present methods.

I wish to enter into my testimony this program integrity handbook prepared by Occidental Life, part B, medicare which has some of the methods by which we use to determine fraud and abuse.

I think it might be helpful to you in your determinations.

Mr. Rostenkowski. Thank you, Doctor. We will file the pamphlet with the committee.

Mrs. Keys?

Mrs. Keys. No questions.

Dr. Olch. Thank you for giving us the time and opportunity to present our testimony.

Mr. Rostenkowski. Thank you, Doctor, once again.

Dr. Gullattee?

[No response.]

Mr. Rostenkowski. Carolyn Bode?

Welcome back to our committee, Ms. Bode.

Ms. Bode. Thank you.

Mr. Rostenkowski. If you will identify yourself, you may proceed.

STATEMENT OF CAROLYN BODE, DIRECTOR, ABORTION AND HEALTH PROJECTS, WOMEN'S LOBBY, INC.

Ms. Bode. Mr. Chairman, members of both committees, I am Carolyn Bode, director of abortion and health projects for the Women's Lobby, Inc. The lobby is a national organization with affiliates in 40 States. We work exclusively on legislation pertaining to women. It is a privilege to appear before you.

I am testifying today because women are poorer than other people. The issue of medicare and medicaid fraud is a serious one for women because we are overrepresented in the recipient population.

MEDICARE

Women are two-thirds of the elderly and by the year 2000 women over 65 will be 20 percent of the U.S. pouplation.[1] Because these women have annual incomes of less than $2,000 a year, they are almost incapable of meeting the copayment and deductible amounts required under current medicare regulations.[2]

Each $4 copayment and the initial $124 deductible is a large percentage of this tiny income. On January 1, HEW raised the medicare hospital deductible and other health related charges by almost 20 percent. The deductible for the first 60 days of hospital care in a single-benefit period went from $104 to 124; the coinsurance payment for the 61st day to the 90th day rose from $26 to $31, and for stays of more than 90 days from $52 to $62.[3]

In some ways the 14 percent of women over 65 who have no income at all are better off in health care because they are also medicaid eligible.[4] Women use roughly 50 percent of the medicare dollar (though we are two-thirds of the elderly). Using Senator Moss' figure of $1 in every $6 being fraudulent, women are paying $308.-170 million to be cheated of their meager livelihoods.[5]

Ironically, they are being cheated by a medical profession that is only 17 percent female and a hospital system that does not use them in any real executive capacity. Once again sex discrimination robs the poorest women to line the pockets of the wealthiest white men.[1]

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[1] Federal Council on the Aging, Annual Report, Jan. 16, 1976, p. 65.

[2] Bureau of Census, Current Population Reports, Special Studies, Social and Economic Characteristics of Older Population, 1974. series P–23, No. 57, p. 37.

[3] Health Security News, Committee for National Health Insurance, 6:1, Jan. 28, 1977, p. 2.

[4] U.S. Congress, House of Representatives, Committee on Aging, Subcommittee on Retirement Income and Employment, 1st Sess., 94th Cong. Hearing, "Social Security Inequities Against Women" Sept. 11 and 29, 1975, p. 3.

[5] HEW SSA 76 11927, Compendium of National Health Expenditures Data, table 20.

MEDICAID

Medicaid recipients are 56 percent women and their children on AFDC. That is almost 5 million people, drawn from a group that is 97 percent women and children. So of the $51.473 million spent on their health care at this rate of fraud, that is nearly $6.579 million taken from Federal funds that might go to broader programs, covering the 6 million AFDC recipients who are not medicaid eligible, and more preventive care in the form of early preventive screening and diagnostic treatment.[2]

LONG-TERM CARE

These women who are on AFDC are hurt by medicaid fraud in a real and tangible way, for States that have a cost overrun on medicaid try to make up those costs by cutting back on welfare. They may not actually lower the base grant, but they may keep the State office open only a few hours a day, or at odd times; they may change regulations or institute several new ones; or they may eliminate the outreach programs, effectively discouraging usage, and so cutting down on welfare payments. To cite one specific example, in Nevada the State instituted 26 regulations governing early periodic screening, and despite numerous phone calls the women at a clinic that did the screening were unable to find anyone official who could correctly interpret these regulations for them.[3]

According to a study done by the Federal Council on the Aging, elderly women need long-term care. We do not go into the hospital for a short period and quickly die. Special attention has been paid to the need for catastrophic care, but among the elderly that amounts to only a tiny percentage.[4]

Women linger on for years, gradually eating up their small financial resources, in some cases having to switch finally over into medicaid, unless they still own a house and then they are not eligible for even that.

Women need long-term care; they need preventive care; and neither medicaid nor medicare is covering these needs adequately.

ENDORSEMENT

We applaud this joint hearing and the effort to control the costs and fraudulent abuse of these programs. We wholeheartedly support this legislation because it rectifies problems in a program that works against the people it was designed to serve: the poor.

Even those who do not benefit from these programs bear, as women, an inordinate tax burden because we are low wage earners who are taxed under income splitting provisions. Because we are often marginally employed, we make up the AFDC rolls when we are unemployed and heads of households; because we live longer, we will eventually use these programs. For all these reasons, it is in our best interest to end abuse in the programs.

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[1] U.S. Department of Labor, Women's Bureau, 1975 Handbook on Women Workers, p. 12.

[2] DHEW SRS 76 03150, NCSS report B-1 (12/75) Medical Assistance (Medicaid) Financed Under Title XIX of the Social Security Act, table A-2.

[3] Unpublished thesis by Edward Zuckerman, p. 23.

[4] Federal Council on the Aging, Annual Report, 1975, Jan. 16, 1976, p. 65.

ABORTION

There is another example of medicaid fraud that concerns us at the Women's Lobby. This is the avowed intention of President Carter and HEW Secretary Califano to withhold medicaid funding for abortions. We cannot countenance this double standard, one for the rich and one for the poor.

The Supreme Court has recognized that every woman has the right to decide whether or not to terminate a pregnancy. Poor women and girls must be able to exercise this right as well as rich. Medicaid must continue to repay doctors for abortion services. As well, this bill must ruthlessly stamp out the abortion clinic fraud that endangers the lives of women. When an incomplete abortion is done to bill medicaid twice for the same procedure, the cost in dollars cannot be compared to the costs in deaths of those women.

SUMMATION

Medicare and medicaid offer the promise of good health care to those who cannot afford to find health care in the private sector. The fact that women are proportionately overrepresented in the population of those receiving services that do not meet their needs is an example of base fraud.

The women's lobby supports this legislation, but when the matter of medicare and medicaid reform is under consideration we urge the committees to remember the needs of women for preventive care, long-term care, and abortion services, and to ensure that the health programs are responsive to them.

Thank you.

Mr. Rostenkowski. Thank you, Ms. Bode.

Mrs. Keys?

Mrs. Keys. No questions.

Mr. Rostenkowski. Thank you very much.

Mr. Morderosian.

Welcome back to the committee, Mr. Morderosian.

STATEMENT OF LAWRENCE D. MORDEROSIAN, PORTLAND, OREG.

Mr. Morderosian. It is becoming a habit. I wish you paid my way.

Mr. Chairman, members of the committee, I would like to personally offer sincere thanks for letting me come back up on this thing. Like I say, it is becoming a habit, but I am hoping it will do some good.

My name is Lawrence D. Morderosian and I reside at 2145 NW. 135th Avenue, Portland, Oreg. 97229.

I am making this presentation on behalf of my father, Lyon Morderosian, who is 86 years old, but, unable to attend this hearing, due to slow recovery from a serious injury in 1976.

I am a Federal Government employee, but I would like to say what I am doing has been on my own. It is paid for by my own expense. I take annual leave when I get involved, so no one can make any complaints about it.

I would like to thank the committee for allowing me to appear in person.

To start off, I was going to read what I typed last week and go into it. While I was flying in yesterday from Portland, I got to thinking about a lot of things that have come up in the meantime after the Oregon paper published an article that I was going to come up on this hearing. I got 27 phone calls in a matter of about 3 hours the day the paper published it. I proceeded to take a look at some of the allegations of fraud that came into me from the people who had been victims of it.

As a result of that, I got into it rather heavy. I found that the present fraud and abuse provisions of the act are either too weak and comparable to a paper tiger or there has been a minimal effort to enforce the police functions by no response of the Federal and State officials.

I can assure the members of this committee as well as the entire Congress that the persons that I have spoken to from Washington, D.C., St. Louis, and as far as Hawaii, have been one of great concern. That is the growing distrust of officials to protect the health and welfare of the elderly as well as physically disabled persons in the community.

In my personal contacts with groups of concerned citizens ranging in numbers from 100 to 500 members, I have found there is a great expectation of improvement by these people in the extremely neglected health programs to the elderly persons.

There are great expectations of improvement, especially now that President Carter has indicated his concern for the health and welfare of the people.

Incidentally, I would like to assure this committee I have had extensive training and experience in the investigative field since 1955. My main specialty has been investigations of allegations of fraud against the Federal Government. A detailed summarization of my qualifications can be found in the attachment of the written statement which I would like to have included in the printed record of the hearings on H.R. 3.

Mr. Rostenkowski. Without objection, so ordered.

Mr. Morderosian. At the requests of my sources, the names of individuals who provided me with vital information on acts of fraud and abuse committed in the past and presently must be treated as confidential. I can assure this committee that the persons supplying this information were knowledgeable and in positions where the rule of hearsay evidence can be ignored.

In addition, many sources are presently intrinsically involved in their working capacity in positions which provide direct contact with medicare and medicaid programs.

Of course, senior citizens, as well as physically handicapped also were invaluable sources of information. What I would like to emphasize is that my testimony before this committee is based upon excellent sources of information as well as my own personal investigation of the matters.

Briefly, my sources of information included, but were not limited, to several cooperative physicians, active and retired nurses, hospital, office personnel, nursing home employees, including part and full-time aides and attendants, kitchen help, janitors, food suppliers to nursing homes, and a former supervisor.

I realize that time is of the essence to this committee. I will try to limit this testimony to the basic hard facts which I believe will be of interest. In examining and evaluating this information, I used the definitions of fraud and abuse as stated in Blacks Law Dictionary where it says fraud consists of some deceitful practice or willful device resorted to with the intent to deprive someone of his right or in some manner to do him injury.

Abuse is to make improper use of a thing or to employ in a manner contrary to natural or legal laws for its use. Those were the major parts of the definitions I attempted to follow.

The following listing is not in order of importance. However, it is my interpretation of their inclusion in violation of laws against fraud or abuse of the medicare-medicaid programs.

INVOLVING PHYSICIANS

One: Claims for medical services not acutally performed. Example, where the physician was allegedly the operating surgeon, however, he observed, but actually did nothing for the performance of the surgery. However, he billed the patient as having been the performing surgeon;

Two: The claim of hospital regulations that require the attendance of as many as four doctors for an operation where only one doctor actually performed.

Three: And this is a nice one—the claim that additional doctors are needed for surgical operations in case the operating surgeon has a heart attack or there is an earthquake or some other major catastrophe.

Four: This is mainly under the nursing homes — I will skip that part.

Under hospital, claims for first class food costs for inferior quality food actually served. Use of unqualified minimal paid ward attendants, but with claimed submittals for highly qualified personnel. Tremendous inflated costs for medicine. For example, aspirins were costing anywhere from 20 to 25 times as much as you could buy them on the outside retail market.

Claims which included physical therapy for patients who were incapable of leaving a bed. Fictitous claims for services never performed or overhead costs which had been padded heavily. Example: working on a patient as a specialist, but actually a low paid attendant.

Now we come to nursing homes. Substandard facilities with highly inflated prices, low qualified, low paid employees, low quality food served at exorbitant prices, improper medical treatment but claims of physicians care for medical care by nurses, unregistered nurses who were in absolute control of the helpless patients.

The other part I had here was failure of physicians to actually make the rounds, mainly in nursing homes. I have had many persons who worked at the nursing homes advise me that in the majority of the instances, doctors will visit the administrative office, look at patients' charts, and make such notes progress stable, continue medication, making as many as 20 to 25 so-called visits while sitting in the office and billing the Federal Government programs for $15 to $25 for each alleged visit.

Then I go further with forced physical therapy, cases where wheelchair patients were throwing beanbags back and forth. This was termed extremely active physical therapy. They were so billed under the medicaid program.

Advance notice of inspections by Federal and State officials to the nursing homes allowed the nursing homes a 24-hour minimum time of an inspection at which time the place became absolutely spic and span. In one instance which I thought was quite the situation — they rented a color TV set for 1 day and had it turned back in the day after the inspection was over.

These are points which I think should be looked at in more detail by anybody. It is fraud no matter how you look at it. When they make claims for this where they collect for services not rendered. I think, on the television last week on the 60 minutes program, part of that was on this in regard to the doctors that did not do the operation but billed the patient for it.

I will just excerpt a few items from this lengthy typed statement here.

The senior citizens and disabled persons have been neglected and their needs ignored, for too many years. They have been treated like animals in a zoo; when ill, they have been used in experiments to know how to medicate others properly, or have been put out to pasture and forgotten.

The U.S. statistical abstract reflects that there are over 25 million persons 65 years or older. In addition, there are many millions of handicapped and/or disabled persons who are also enrolled in the medicare-medicaid programs. This group is increasing every day. I believe it would be correct to describe the situation as a sleeping giant that is rapidly coming to life. Many people have asked me why I have become so deply involved in this challenge to the medicare-medicaid problem areas, that I have been called the Ralph Nader of medicare.

My answer to these queries is straigh forward and to the point, I served over 3 years in the military services during WW II, and, after that service, I attended college under the G.I. bill. My parents could not have afforded to send me to college. The senior citizens of today were the working citizens who paid for my college education in the late 40's. My involvement and interest in the medicare-medicaid programs, is my way of expressing my gratitude to the people who paid for my college education. It is unfortunate that many of today's doctors and dentists, who were able to attend medical school under the same G.I. bill, have forgotten this indebtedness to these elderly persons.

I go on some more here. Maybe I misinterpreted what the bill says, R.R. 3. Under section 2, "Prohibition Against Assignment by Physicians and Others of Claim for Services".

When I read this section, I felt that the committee might not be aware of some of the devious tactics or practices used by dentists, physicians, hospitals, and nursing homes, to collect money allegedly owed them by senior citizens. Here you see a threat of an assignment of claim, by a doctor, to a collection agency, unless immediate payment is made to this doctor. This classical piece of trash was sent to my 85 year old father. Like the average senior citizen, he was scared. Such unsigned, form letter threats are the most commonly used threat to the senior citizens by collection agencies.

I invited both the doctor and the collection agency to file a civil suit. Neither responded to my suggestion. I then queried the medicare claim administrator, Aetna Life Insurance and Casualty Co., as to clerical error by its organization, with no response. I received advice from the physician — see attachment No. 1 — that the cost should have been covered by medicare. This error by the carrier was finally corrected.

I consider this information to be pertinent to this hearing, because of the serious problems created by assignment of claims to collection agencies. In this instance, if there had been court action by the doctor/collection agency, I would have filed a civil suit against the carrier for the damage to my father's reputation, due entirely to carrier error. However, the agreement between the carrier and the HEW, provides the carrier with complete freedom from any civil suits and judgements. The Federal Government assumes full responsibility for the costs of any suits and judgements in civil suits involving all medicare carriers.

The Portland, Oreg. telephone book, provided me with information about collection agencies, which I believe merit serious consideration. I found one agency with the name, "Doctors Official Service Bureau, Inc." Below the agency name was the statement, "Endorsed by the Multnomah County Medical Society."

I called this agency and was advised that this agency had leased the office from the Doctors Official Service Bureau, Inc., and its name was "Capital Credit and Collection Service, Inc." This agency is not listed in the telephone book. I visited their offices and found there was a third collection agency named "Northwest Adjustment Co.," also using the same office. I was informed that the main workload of all of these agencies was based on assignment of claims by dentists, doctors, and hospitals.

They claimed they charged from 40 percent to 50 percent of money collected. When I asked for copies of the forms used, and explained why I wanted them, they refused to supply any further information. I contacted two other collection agencies, who confirmed that the collection fees for medical bill collection ranged from 40 to 60 percent of the money collected. One agency stated it sold books of 6 form letters for $7.48. They sent these letters out. If no response was received, the client has a choice of dropping the claim, or hiring the agency at a rate of 40 to 55 percent of money collected.

In examining section 3, "Disclosure of Ownership and Financial Information", I noticed that there was no reference to the identification of doctors, dentists, or medical groups, that had involvement in nursing homes, hospitals, or other types of group medical institutions. It was not too difficult to determine, from highly reliable sources, that many physicians have vested financial interests in these types of facilities.

The reasons include tax shelters and investments, as well as guaranteed numbers of patients to file claims for provider services for the patients, or, from the evidence developed by interested senior citizen organizations, such as the Grey Panthers, perhaps the word "inmate" might be more appropriate.

This section of the bill should definitely include nursing homes, hospitals, and any facility which provides care and/or shelter for medicare/medicaid program participants. I have spoken to many persons, who confirmed that the doctors who provided medical services for members of their family enrolled in the medicare/medicaid programs, had strangly urged them to have relatives placed in specific nursing homes. Some had the same encouragement for placing relatives in specific nursing homes from hospitals, where they had been under medical care.

When my father broke his hip last April, the doctor in charge was a little surprised — (my father was in the hospital for 3 weeks). He is 86 — When I practically forced him to release my father from the hospital, he wanted to know what nursing home I wanted him in. I said no nursing home, he goes home. He couldn't understand. He said "I will let him go in the next few days."

The hospital then asked what nursing home I wanted him sent to. I think they meant well, but it was against the grain for me.

I realize that I have concentrated heavily on the potential dangers found in nursing homes.

The purposes of these definition references in my statement, is to point out that the commitment of fraudulent acts and/or abuse, which is the subject of this hearing, have occurred in the past, occur today, and will continue to occur in the future, in nursing homes, hospitals, and other such facilities, unless there is adequate legislation to preclude such actions.

The majority of State agencies which have the legal responsibility, have continually ignored or delayed conducting criminal investigations and/or prosecution of individuals or organizations guilty of fraud or abuses in these establishments, mainly nursing homes.

The only way that Congress can prove to the Nation that it is willing to protect the right of the helpless patients to live, is to include all aspects of the operation of all medical institutions—nursing homes, hospitals, old folks homes which collect these funds, etc.—within the purview of this bill.

I believe that Congress should consider the establishment of an inspector general to oversee the implementation of rigid control and adherence to the intent of the medicare/medicaid programs at State government levels.

I realize that the establishment of an inspector general office was mentioned by Mr. Califano in his testimony this morning.

I believe President Carter has endorsed the establishment of inspector generals in the various Federal agencies. In my many years of active duty in the Air Force, private employment as a management/investigative consultant, and employment as a senior level civil servant, I found that there is greater respect for compliance with the DOD and Federal regulations, when there is an inspector general assigned to an organization, who operates independently of any control except the top executive of that organization.

I would like to express my sincere appreciation to this committee for allowing me to testify. It might be interest to this committee and Congress to know that I sent a copy of the hearing held before this committee on September 15, 1976, with my testimony recorded therein, to my father's relatives in Yerevan, Soviet State of Armenia, U.S.S.R. My father, like his predecessors, before he fled to the United States in 1913, during the genocide of Armenia by the Turkish Government, belonged to a group known as the Tashnigans, or the Armenian Revoluntionary Forces. This mailing was my father's way of telling the relatives in Russia, that in our country, any citizen, rich or poor, can testify before the Congress of the United States, without fear of being exiled or imprisoned.

Thank you for allowing me the privilege of appearing before this committee to express my opinion, and that of many persons of all ages, who are becoming increasingly concerned over the continued rape of our Republic's economy, by minority interests, which have majority fiscal control in national health matters.

I ask that if any person or organization is allowed to present a rebuttal to my testimony or statement, that I be allowed to respond to that rebuttal.

I would like to mention that I met yesterday with Ms. Caroline Wellons, one of President Carter's aides, in regard to my challenge to the problems that I have found in the medicare program.

I am having another meeting with two more of the President's aides tomorrow. Frankly, it is quite a great feeling to find out that the President of the country is really interested in something like this and contacts you to come up and talk to his people and find out what is going on.

With that, I better get out of your wey.

[The prepared statement and attachments follow:]

Statement of Lawrence D. Morderosian

My name is Lawrance D. Morderosian, and I reside at 2145 N.W. 135th Avenue, Portland, Oregon 97229. I am making this presentation on behalf of my father, Lyon Morderosian, who is 86 years old, but, unable to attend this hearing, due to slow recovery from a serious injury in 1976. I also have the privilege of speaking on behalf of many Senior Citizens who are unable to attend due to lack of financial capability, and, a significant number of persons who are presently working, or have worked for, medical facilities in the past. For understandable reasons, these persons have asked to remain anonymous because of their job security.

Initially, I would like to commend the Members of this Committee, on their concern for the Senior Citizens who are enrolled in the Medicare and Medicaid Programs. These citizens have been neglected and their needs ignored, for too many years. They have been treated like animals in a zoo; when ill, they have been used in experiments "to know how to medicate others properly," or have been "put out to pasture" and forgotten. The U.S. Statistical Abstract reflects that there are over 25 million persons 65 years or older. In addition, there are many millions of handicapped and/or disabled persons who are also enrolled in the Medicare-Medicaid Programs. This group is increasing every day. I believe it would be correct to describe the situation as a "sleeping giant" that is rapidly coming to life. Many people have asked me why I have become so deeply involved in this challenge to the Medicare-Medicaid problem areas, that I have been called the "Ralph Nader of Medicare." My answer to these queries is straightforward and to the point. I served over three years in the military services during WW II, and, after that service, I attended college under the G.I. Bill. My parents could not have afforded to send me to college. The Senior Citizens of today were the working citizens who paid for my college education in the late 40's. My involvement and interest in the Medicare-Medicaid Programs, is my way of expressing my gratitude to the people who paid for my college education. It is unfortunate that many of today's doctors and dentists, who were able to attend medical school under the same G.I. Bill, have forgotten this indebtedness to these elderly persons.

In reviewing H.R. 3, I found that the Bill has great merit. However, I believe that the complexity of the terminology, preclude anyone except an attorney from comprehending the meaning and intent of the majority of the Bill. Our Senior Citizens, for whose benefit the Bill was written, could not afford to pay an attorney $35.00 to $50.00 an hour for interpretation of the meaning of the Bill, with their low, fixed income. I suggest that a brief, but, easily understood statement, be published for the benefit of the Senior Citizens, when the Bill becomes law.

In regard to my comments on areas of the Bill which might be considered by the Committee, I submit the following:

(1) Sec. 2, "Prohibition Against Assignment by Physicians and Others of Claim for Services." When I read this section, I felt that the Committee might not be aware of some of the devious tactics or practices used by dentists, physicians, hospitals, and nursing homes, to collect money allegedly owed them by Senior Citizens. Please refer to Attachment No. 1. Here you see a threat of an assignment of claim, by a doctor, to a collection agency, unless immediate payment is made to this doctor. This classical piece of trash was sent to my 85 year old father. Like the average Senior Citizen, he was scared. Such unsigned, form letter threats are the most commonly used threat to the Senior Citizens by collection agencies.

I have a very low opinion of collection agencies, per se, which have been aptly described as "bleeders." I invited both the doctor and the collection agency to file a civil suit. Neither responded to my suggestion. I then queried the Medicare Claim Administrator, AETna Life Insurance and Casualty Company, as to clerical error by its organization, with no response. I received advice from the physician (See Attachment No. 1), that the cost should have been covered by Medicare. This error by the Carrier was finally corrected. I consider this information to be pertinent to this Hearing, because of the serious problems created by assignment of claims to collection agencies. In this instance, if there had been court action by the doctor/collection agency, I would have filed a civil suit against the Carrier for the damage to my father's reputation, due entirely to Carrier error. However, the agreement between the Carrier and the HEW, provides the Carrier with complete freedom from any civil suits and judgments. The Federal Government assumes full responsibility for the costs of any suits and judgments in civil suits involving all Medicare Carriers.

As I stated to this Committee, when I testified before it on September 15, 1976, the agreement between the Carriers and the HEW is faulty, and, in my opinion, not written in the best interests of the Government, but, mainly to benefit the Carriers. Especially the excessive administrative cost provisions.

The Portland, Oregon telephone book, provided me with information about collection agencies, which I believe merit serious consideration. I found one agency with the Name, "Doctors Official Service Bureau, Inc." Below the agency name was the statement, "Endorsed by the Multnomah County Medical Society" (See Attachment No. 2). I called this agency and was advised that this agency had "leased" the office from the "Doctors Office Service Bureau, Inc.", and its name was "Capital Credit and Collection Service, Inc." This agency is not listed in the telephone book. I visited their offices and found there was a third collection agency named "Northwest Adjustment Company", also using the same office. I was informed that the main workload of all of these agencies was based on assignment of claims by dentists, doctors, and hospitals. They claimed they charged from 40% to 55% of money collected.

When I asked for copies of the forms used, and explained why I wanted them, they refused to supply and further information. I contacted two other collection agencies, who confirmed that the collection "fees" for medical bill collection ranged from 40%–60% of the money collected. One agency stated it sold "books" of six form letters for $7.48. They sent these letters out. If no response was received, the client had a choice of dropping the claim, or hiring the agency at a rate of 40%–55% of money collected. I was unable to buy one of these books, for obvious reasons. H.R. 3 is not too clear as to its positive application to collection agencies of this nature. I recommend that the Bill be amended to void this type of assignment of claims in Medicare—Medicaid matters.

In examining Sec. 3, "Disclosure of Ownership and Financial Information", Page 5–13, I noticed that there was no reference to the identification of doctors, dentists, or medical groups, that had involvement in nursing homes, hospitals, or other types of group medical institutions. It was not too difficult to determine, from highly reliable sources, that many physicians have vested interests in these types of facilities. The reasons include tax shelters and investments, as well as, guaranteed numbers of patients to file claims for provider services for the patients, or, from the evidence developed by interested Senior Citizens organizations, as the Grey Panthers, perhaps the word "inmate" might be more appropriate.

This section of the Bill should definitely include nursing homes, hospitals, and any facility which provides care and/or shelter for Medicare/Medicaid Program participants (See Attachment No. 3). I have spoken to many persons, who confirmed that the doctors who provided medical services for members of their family enrolled in the Medicare/Medicaid programs, had strongly urged them to have these relatives placed in specific nursing homes. Some had the same encouragement for placing relatives in specific nursing homes from hospitals, where they had been under medical care.

I realize that I have concentrated heavily on the potential dangers found in nursing homes. There has been nationwide publicity and concern over the extremely poor living conditions, and, failure to provide adequate medical care for the helpless residents (inmates?). This Hearing is confined to two types of criminal actions: Fraud and Abuse. Black's Law Dictionary, Fourth Edition, defines these words, in part, as: Fraud;; "It consists of some deceitful practice or willful device, resorted to with intent to deprive another of his right, or in some manner to do him injury"; Abuse; "to make excessive or improper use of a thing, or to employ it in a manner contrary to the natural of legal rules for its use". It is not my intention to lecture on legal definitions.

The purpose of these definition references, is to point out that the commitment of fraudulent acts and/or abuse, which is the subject of this Hearing, have occurred in the past, occur today, and will continue to occur in the future, in nursing homes, hospitals, and other such facilities. The majority of State agencies which have the legal responsibility, have continually ignored or delayed conducting criminal investigations and/or prosecution of individuals or organizations guilty of fraud or abuses in these establishments, mainly nursing homes. The only way that Congress can prove to the nation that it is willing to protect the right of the helpless patients to live, is to include all aspects of the operation of all medical institutions (nursing homes, hospitals, old folks homes which collect these funds, etc.), within the purview of this Bill.

I have had only two weeks, working evenings and weekends, to conduct an investigation of the possibility of fraud in the high cost of hospitals and nursing homes patronized by Medicare Health Plan members. Let me assure this Committee that I have been a fully qualified investigator, for the Federal Government, as well as in private practice, since 1955 (See Attachment No. 4). Admittedly, time has been very short, however, I have had assistance from interested persons, including current and previous hospital nursing home employees, who have informed me that there is virtually no control over the inclusion of costs for medication (at highly inflated rates compared to normal routine prices), claims of in-house physical services not provided patients, highly inflated costs for food served patients, and so forth. My father spent over 1½ months in the same hospital when he broke his hip in 1976. I have no personal vendetta or grudge against the hospital in which he was a patient. The personnel were excellent and very conscientious. However, the quality of the food at the cost claimed, was questionable. It is virtually impossible to prove or disprove the costs claimed by the hospital (in excess of $11,500.00) for quarters, food, medication, etc., unless someone is present at each instance of application. However, it is interesting to note that under Part A of the Medicare Act, the hospitals, where there is no real control or monitor system of costs, are reimbursed 100% of claimed cost, and have a right to appeal any cost dispute, while under Part B, the patient, who cannot manipulate or gain financially, has no way or right to appeal cost dispute except to the Carrier, which denied the cost in question, a totally unfair situation. Under Part A and Part B, fiscal control resides with Carriers. I include Blue Cross/Blue Shield in that category (Part A).

The false submission of a claim for reimbursement from Federal agencies, is fraud. I suggest that the Committee consider including in this Bill, provisions which will insure criminal prosecution for false claim submittals by hospitals and nursing homes. I believe too much attention has been paid to potential fraudulent acts by physicians, while virtually no attention has been paid to hospitals and nursing homes.

In examining the Social Security Act, and the pending Bill, I noticed that there was nothing referenced in regard to the transfer of fiscal responsibility for the Medicare/Medicaid program to State control. This, to me and many others who have discussed this matter, is questionable, because of the obvious schism which exists in the Federal/State administrative responsibility. The influence of Lobbies, which represents the various professional and health institutions, at State Legislative Hearings, has as much, if not more, influence on the State Government, than the Lobbies or these same interests in Washington, D.C.

I believe that Congress should consider the establishment of an Inspector General to oversee the implementation of rigid control and adherence to the intent of the Medicare/Medicaid programs as State Government levels. This is not meant to advocate a police state type of action, but, to conduct periodic examinations of the expenditures of Medicare/Medicaid funds, which are under the control of State agencies. I believe that President Carter has endorsed the establishment of Inspector Generals in the various Federal agencies. In my many years of active duty in the Air Force, private employment as a management/investigative consultant, and employment as a senior level civil servant, I found that there is greater respect for compliance with the DOD and Federal Regulations, when there is an Inspector General assigned to an organization, who operates independently of any control except the top executive of that organization.

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Thank you for allowing me the privilege of appearing before this Committee to express my opinion, and that of many persons of all ages, who are becoming increasingly concerned over the continued rape of our Republic's economy, by minority interests, which have majority fiscal control in national health matters.

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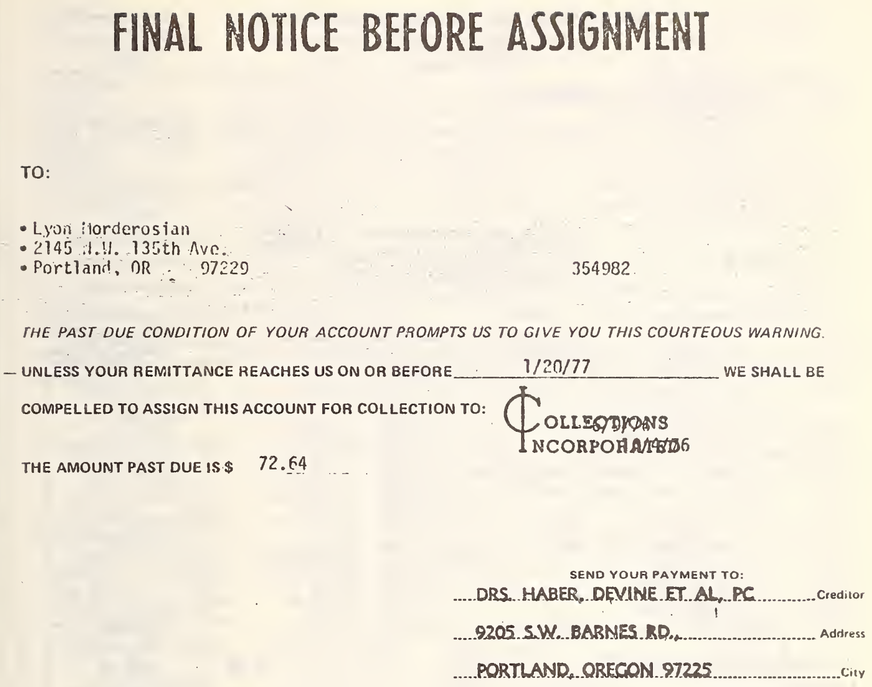

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- 2145 N.W. 135th Ave.
- Portland, OR 97229

354982

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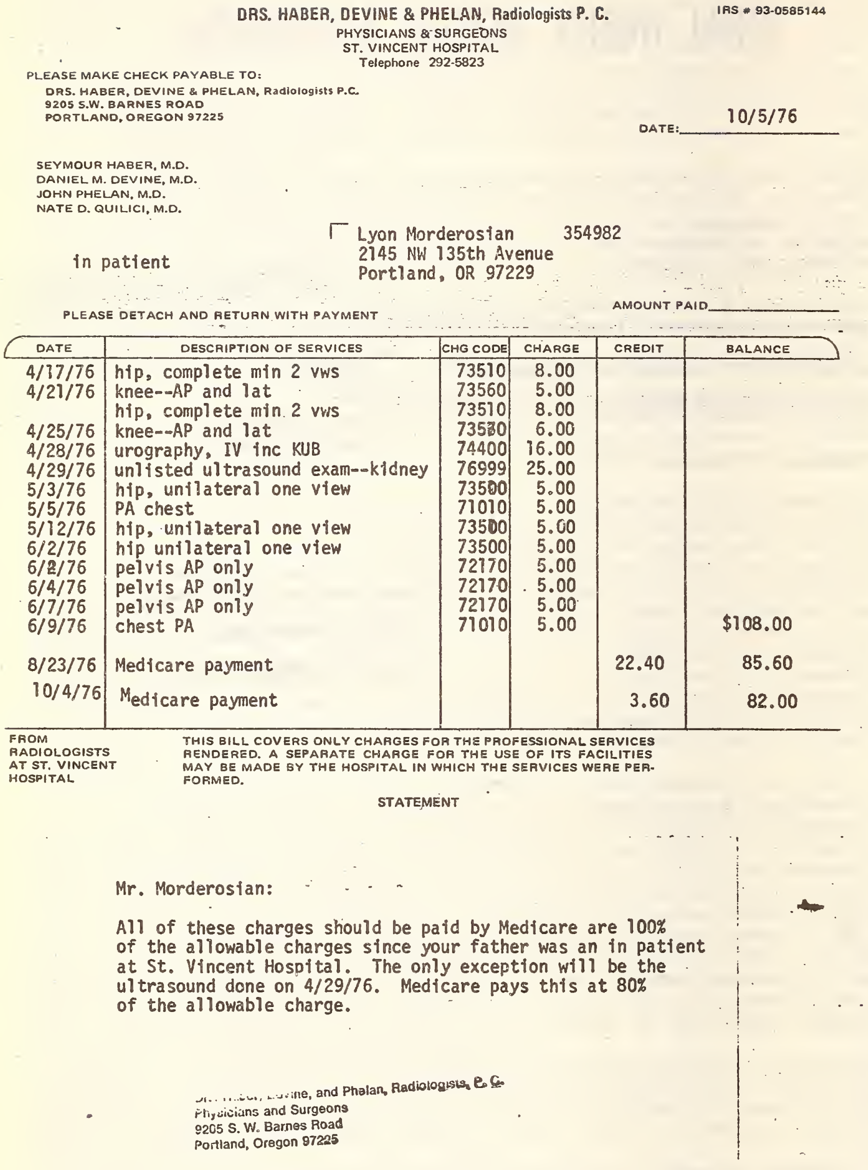

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9205 S.W. BARNES ROAD
PORTLAND, OREGON 97225

DATE: 10/5/76

SEYMOUR HABER, M.D.
DANIEL M. DEVINE, M.D.
JOHN PHELAN, M.D.
NATE D. QUILICI, M.D.

Lyon Morderosian 354982
2145 NW 135th Avenue
Portland, OR 97229

in patient

AMOUNT PAID__________

PLEASE DETACH AND RETURN WITH PAYMENT

DATE	DESCRIPTION OF SERVICES	CHG CODE	CHARGE	CREDIT	BALANCE
4/17/76	hip, complete min 2 vws	73510	8.00		
4/21/76	knee--AP and lat	73560	5.00		
	hip, complete min 2 vws	73510	8.00		
4/25/76	knee--AP and lat	73530	6.00		
4/28/76	urography, IV inc KUB	74400	16.00		
4/29/76	unlisted ultrasound exam--kidney	76999	25.00		
5/3/76	hip, unilateral one view	73500	5.00		
5/5/76	PA chest	71010	5.00		
5/12/76	hip, unilateral one view	73500	5.00		
6/2/76	hip unilateral one view	73500	5.00		
6/2/76	pelvis AP only	72170	5.00		
6/4/76	pelvis AP only	72170	5.00		
6/7/76	pelvis AP only	72170	5.00		
6/9/76	chest PA	71010	5.00		$108.00
8/23/76	Medicare payment			22.40	85.60
10/4/76	Medicare payment			3.60	82.00

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HOSPITAL

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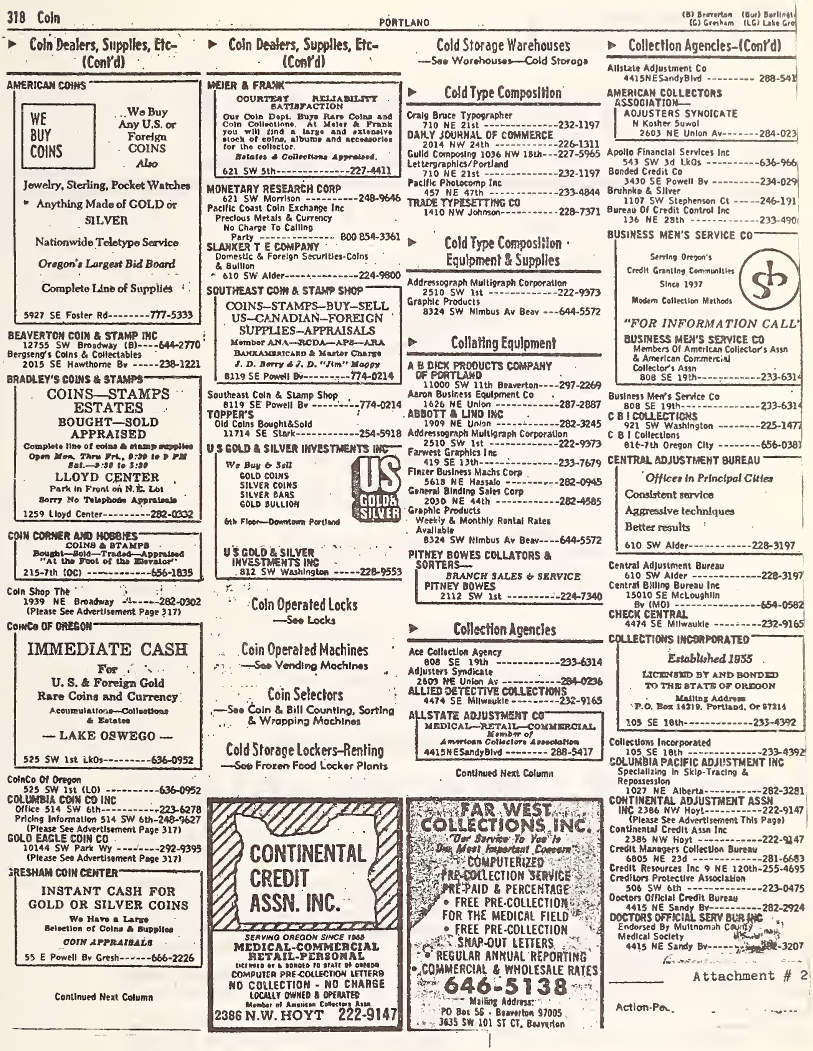
STATEMENT

Mr. Morderosian:

All of these charges should be paid by Medicare are 100% of the allowable charges since your father was an in patient at St. Vincent Hospital. The only exception will be the ultrasound done on 4/29/76. Medicare pays this at 80% of the allowable charge.

Drs. Haber, Devine, and Phelan, Radiologists, P. C.
Physicians and Surgeons
9205 S. W. Barnes Road
Portland, Oregon 97225



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Attachment # 2

Action-Pe.

Oregon Journal

Friday, February 25, 1977

Crusader asks data

By DENNIS McCARTHY
Journal Staff Writer

Seniors advocate Larry Morderosian continues to enlist public support in his battle to reform the multibillion dollar Medicare program he claims is ripping off millions of elderly Americans.

Morderosian leaves Portland next week for Washington, D.C., to testify before the House Committee on Health March 3 and March 7 on a bill to eliminate fraud and abuses in the Medicare and Medicaid acts. "

"I am asking anyone who can provide me with information about known fraud or abuses of the Medicare or Medicaid programs to contact me (645-4864) as soon as possible," he said.

Among other provisions, the bill would prohibit assignment of medical claims by physicians, dentists, hospitals and nursing homes and requires public disclosure of those having financial interest or ownership in medical clinic, pharmacies and other medical facilities.

It also prescribes more severe penalties on those who defraud Medicare or Medicaid recipients.

Morderosian says he will also testify on the need for national minimum standards for the operation of nursing homes. He will be asking Congress to begin an investigation of the nursing home industry to eliminate patient abuses.

Medicaid probers awaited

By MARGE DAVENPORT
Journal Special Writer

A once-postponed investigation of possible fraud and abuse of Oregon's multimillion-dollar Medicaid program will start Monday, state and federal officials announced.

The earlier postponement by the Seattle office of the U.S. Department of Health, Education and Welfare had caught Oregon Human Resources Department officials off guard. They were under the impression that Washington, D.C., investigators already were in the state.

A state spokesman said Thursday that he understands the investigation will proceed as a result of an agreement as to who will prosecute if any fraud is found and how much time Oregon will have to correct any abuses discovered.

Medicaid provides health care for the poor and is funded jointly by state and federal revenues.

HEW officials said confusion over rescheduling of the investigation stems from new HEW Secretary Joseph A. Califano Jr. shifting emphasis to welfare reform.

Charles Peppler of the Seattle HEW office said the main emphasis will be on welfare reform during a hearing March 14 in Portland.

Because of a shortage of funds, only two or three investigators from Seattle will look into the Oregon Medicaid operation, he added, noting that he is not certain whether anyone from Washington, D.C., will participate, as originally planned.

The probe will be statewide — not centered in one or two major cities.

Investigators are expected to study Oregon physician, pharmacy and laboratory welfare charges.

Peppler said charges of Medicaid fraud and abuses also will be discussed at the hearing.

Groups and individuals will be given an opportunity to express their views at a later hearing, Peppler said.

Attachment #

RESUME'

LAWRENCE D. MORDEROSIAN

EDUCATION: (Civilian) BA, 1951; MBA (Management), 1976.
(Military) USAF Procurement and Contract Administration Schools; 1951, 1952, 1953, 1954, 1955; US Army Procurement School, 1955; USAF Office of Special Investigations School, 1955, 1958, 1959; USAF Intelligence School, 1954, 1962.

LANGUAGES: Armenian, French, German, Spanish.

EXPERIENCE: June, 1973 to Present Time: BONNEVILLE POWER ADMINISTRATION, PORTLAND, OREGON. Contracting Officer on all line construction contracts; assistant to Construction and Services Manager; advise supervisor of developments in executive management, contract activities, safety, Equal Employment Opportunity, and environmental requirements; develop and coordinate programs for improving work effectiveness and relationships; conduct investigations of alleged procurement irregularities.

September, 1972 - June, 1973: BUREAU OF RECLAMATION, DENVER, COLORADO. Assistant to the Branch Chief; assisted in coordinating construction and supply contract activities; assisted in the development of policies and standards for construction contracts and the procurement of materials and equipment; advised the Branch Chief on the formulation of practices and methods for incorporating contract requirements for sophisticated research projects into specifications.

April, 1970 - September, 1972: TRUST TERRITORY OF THE PACIFIC ISLANDS, SAIPAN, MARIANAS ISLANDS. Principal advisor to High Commissioner and Attorney General on all matters concerning contract management; supervised all Trust Territory Department of Public Works personnel engaged in procurement activities; supervised purchases of major electrical power systems and purchases of major construction equipment; provided counsel to all department heads on the FPR guides for contract administration; conducted investigations of alleged procurement irregularities; acted as liaison between Trust Territory and contractor executives from Japan, Korea, Okinawa, and the Philippine Islands.

June, 1964 - April, 1970: SPECIAL INVESTIGATIONS AGENCY, WASHINGTON, D.C. Developed and implemented management analysis programs and procedures for the collection of data and information essential for examining inter-departmental relationships; conducted counter-industrial espionage cases; conducted investigations of corporate operations; conducted performance evaluations, program and progress analysis, and special studies; established work methods and procedures; conducted studies of Contract Management Program to determine adequacy and compliance with ASPRs and FPRs; developed programs to assist managers in identifying, validating and applying cost factors, performance standards, trends, and output measures to evaluate effectiveness of their operations; Public Relations contact between clients and Congressional offices.

April, 1961 - March, 1963:BASE PROCUREMENT OFFICER, USAF. Full supervisory responsibility for procurement actions and administration of contracts; supervised preparation of IFB's for purchase of goods and specialized services; developed data and information relating to costs; negotiated, evaluated price proposals, administered and audited contracts; maintained liaison with government contractors.

January, 1954 - September, 1960: USAF OFFICE OF SPECIAL INVESTIGATIONS. Supervised and conducted investigative and intelligence activities, including criminal, procurement fraud, personnel, etc.; established caseloads for agents depending on complexity of cases; evaluated sources of information and reliability of informants to determine authenticity of the allegations; coordinated investigative and counter-intelligence matters which fell within the provisions of Interagency agreement between DOD, FBI, CIA; main workload was in allegations of procurement irregularities.

June, 1951 - January, 1954: USAF AIR MATERIEL COMMAND. Supervisor in pu
major components for fighter and bomber aircraft; supervisory responsibi
cluded: contract negotiation, administration, price analysis, contractor
terminations, etc.; control of fixed price, R&D, A&E, open-end, letter, CPFF typd contracta; supervised procurement inspection teams which conducted contractor performance surveys; also assigned to Office of the Inspector General.

Attachment #

Mr. Rostenkowski. Thank you very much, Mr. Morderosian. This is the second or third time——

Mr. Morderosian. This is the second time. I hope it will be the last. It is getting expensive.

Mr. Rostenkowski. I want to thank you very much for coming all that way and testifying. We appreciate it very much.

I would like to mention that I certainly enjoyed chairing this meeting. I know that this will dispell a lot of the rumors that people have developed with respect to the cooperation between the Interstate and Foreign Commerce Committee, and the Ways and Means Committee.

This committee will, on Monday next, meet and be the guest of Congressman Paul Rogers at the Interstate and Foreign Commerce Committee at 10 o'clock in the morning.

Mr. Rogers. May I say, Mr. Chairman, it was a real pleasure to participate in these hearings. Our committee is grateful to you and your committee for the fine spirit of cooperation and the very good hospitality you and your staff extended to us. We did enjoy the witnesses today.

I particularly wanted to commend our last witness for his interest and concern as a private citizen to come to Washington from Oregon to make his views known. I think that is most important.

Mr. Morderosian. Mr. Chairman, I came for one other reason also. I am military disability retired. I found it is very expensive to go to private physicians in Portland. I came up here to go to Andrews Air Force Base to see what they can do with my shoulder.

Mr. Rogers. The hearing has been great. You did a magnificent job, Mr. Chairman.

Mr. Rostenkowski. This committee will stand adjourned to meet in the Interstate and Foreign Commerce Committee room on Monday, the 7th at 10 a.m., 2123 Rayburn Building.

[Whereupon, at 4:20 p.m., the hearing was adjourned to reconvene at 10 a.m., Monday, March 7, 1977.]

MEDICARE-MEDICAID ANTIFRAUD AND ABUSE AMENDMENTS

MONDAY, MARCH 7, 1977

House of Representatives,
Subcommittee on Health of the
Committee on Ways and Means, and
Subcommittee on Health and the Environment of the
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittees met jointly, pursuant to notice, at 10:18 a.m., in room 2123, Rayburn House Office Building, Hon. Dan Rostenkowski (chairman of the Subcommittee on Health) and Hon. Paul Rogers (chairman of the Subcommittee on Health and the Environment) presiding.

Mr. Rogers. The joint subcommittees will come to order.

We are continuing today with the joint hearings before the subcommittee of the Ways and Means Committee, Chairman Rostenkowski, and his committee, and the Subcommittee on Health and the Environment of the House Interstate and Foreign Commerce Committee on H.R. 3, a bill to control fraud and abuse in the medicare and medicaid programs.

We had a particularly useful hearing last Thursday on these issues with Secretary Califano of HEW, and a number of very informative witnesses. Partly because of the concern of subcommittee members regarding the commitment of the Justice Department to find and prosecute fraud in our health financing programs. We are pleased the Attorney General will appear before the subcommittee today; and we look forward to his appearance this afternoon.

I might note also that the story appearing in some of yesterday's papers, particularly the Post, that we saw concerning the involvement of organized crime in the health and welfare programs in California, is a situation which is apparently not unique to that State. This situation simply underscores the extreme seriousness of the problems we are dealing with here and the urgent need to take decisive action to protect the integrity of our health financing programs.

We have some distinguished witnesses today. Both committees are anxious to hear them. We have as our first witness our distinguished colleague from Maryland, the Honorable Newton Steers; and we welcome you to the committee. Your statement will be made a part of the record in full at this point. You may proceed as you desire.

STATEMENT OF HON. NEWTON I. STEERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. STEERS. I appreciate the opportunity these distinguished panels have afforded me to discuss costly rental incentives in medicare law which govern reimbursements for durable medical equipment in my bill, H.R. 3296, which would provide for more economical incentives.

Nearly 5 years ago in May of 1972, the General Accounting Office issued a report entitled "Savings Available by Purchasing Durable Medical Equipment When Warranted by Anticipated Period of Need."

The report cited present medicare law which allows beneficiaries to rent such equipment even when the periods of need as indicated by a physician show that purchase of the medical equipment would be more economical.

GAO analyzed the claims histories for durable medical equipment for five insurance companies in four States. The analysis revealed that out of a statistical sample of 420 reimbursements of the approximate 13,000 beneficiaries, a savings of $234,000 including $47,000 for the patients' share could have been realized if the equipment had been purchased when the anticipated period of need indicated that purchase would have been more economical than rental.

Claims histories for a statistical sample of the approximately 7,000 beneficiaries at a sixth carrier in another States revealed that approximately $763,000 including $153,000 for the patients' share could have been realized had the equipment been purchased rather than rented.

I have given several examples cited by GAO which I hope the members will look over. I won't read them. It is sufficient to say, first of all, that they are representative and second, they show individual examples of the kind of savings to the Government and to the patient which I am talking about.

These cases are not surprising. Present medicare law reimburses a beneficiary for the purchase of durable medical equipment in small monthly installments equal to the monthly amounts that would have been paid had the equipment been rented. Medicare beneficiaries who live, for the most part, on shoestring budgets find it most difficult to dole out one big payment in any given month when reimbursement comes in the form of such small payments stretched out over a period of months. One of my constituents last summer wrote about this problem. I would like to read a brief excerpt from this letter; I think this demonstrated to me, a freshman Congressman, that very often out of a case problem you get a legislative solution rather than merely a case solution.

I quote from the letter:

> As you can see from the enclosed notice, I bought a wheelchair on September 30, 1976, from Abbey Rents, for which I paid $147.50. Medicare has informed me that they will reimburse me for the entire cost of the wheelchair, but that the reimbursement will be on the basis of monthly installments. Social Security laws require such a reimbursement to be made in installments *** my difficulty is that I had to pay Abbey Rents the entire amount, but that I will be reimbursed in 'dribbles.' My total monthly income is $332.40 paid as disability insurance by Society Security; the wheelchair cost over one-third of my total

income. It was difficult for me to pay that cost then: it will be even more difficult for me to absorb that cost if I must do it in small installments, especially now that Thanksgiving and Christmas are approaching.

which they were then.

Along these lines, GAO concluded that, when the beneficiaries, rather than the carriers, decide whether to rent or purchase durable medical equipment, they often rent even though anticipated periods of need are long enough to justify purchase.

I introduced H.R. 3269, a bill which simply authorizes the Secretary to make a determination on the basis of medical and other evidence, as to whether purchase of the equipment would be less costly. If such a determination is made, the Secretary may then authorize purchase on a lease-purchase or lump-sum basis.

The bill also provides an incentive to purchase used equipment by waiving the 20-percent coinsurance amount whenever the purchase price of the equipment is at least 25 percent less than the reasonable charge for comparable new equipment.

Finally, the Secretary is authorized to encourage suppliers of durable medical equipment to make such equipment available on a lease-purchase basis whenever possible.

I hope this distinguished committee will give very serious consideration to making more flexible the present method of reimbursing recipients for durable medical equipment. This would serve both the interests of economy and certain hardship cases where beneficiaries cannot afford to be reimbursed for purchase in small monthly amounts.

Again, I thank the committee for giving me this opportunity to discuss the problems of rental abuses in the medicare program.

[The prepared statement follows:]

STATEMENT OF HON. NEWTON I. STEERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman, I appreciate the opportunity which this distinguished panel has afforded me to discuss costly rental incentives in Medicare law which governs reimbursements for durable medical equipment and my bill, H.R. 3296, which would provide for more economical incentives.

Nearly five years ago, in May of 1972, the General Accounting Office issued a report entitled "Savings Available By Purchasing Durable Medical Equipment When Warranted by Anticipated Period of Need." The report cited present Medicare law which allows beneficiaries to rent such equipment even when the periods of need as indicated by a physician show that purchase of the medical equipment would be more economical.

GAO analyzed the claims histories for durable medical equipment for five insurance companies in four states. The analysis revealed that out of a statistical sample of 420 reimbursements of the approximately 13,000 beneficiaries, a savings of $234,000 including $47,000 for the patients' share, could have been realized if the equipment had been purchased when the anticipated period of need indicated that purchase would have been more economical than rental.

Claims histories for a statistical sample of the approximately 7,000 beneficiaries at a sixth carrier in another state revealed that approximately $763,000 including $153,000 for the patients' share, could have been realized had the equipment been purchased rather than rented.

Several examples Cited by GAO were as follows:

"A Medicare patient having heart trouble rented a walker for 16 months. Her physician's prescription stated that the duration of medical necessity would be one year. The monthly rental charges would have equaled the $90 purchase price in five months. The rental charges for the item through August, 1971 were $290.

"A Medicare patient having emphysema rented a respirator for three years. His physician's prescription indicated that the patient would need this equipment indefinitely. The rental charges from September, 1968 through August, 1971 were $1,932. The purchase price of this item was $396.

"A Medicare patient having a chronic, destructive skin condition rented a manual-crank bed with a trapeze bar for nearly four years. The physician's prescription indicated that his patient's condition was irreversible and that equipment would be needed indefinitely. The rental charges from November, 1967 through August, 1971 for the bed and trapeze bar were $1,654 and $342, respectively. The purchase of the items would have cost $284 and $34, respectively."

These results are not surprising. Present Medicare law reimburses a beneficiary for the purchase of durable medical equipment in small monthly installments equal to the monthly amounts that would have been paid had the equipment been rented. Medicare beneficiaries who live, for the most part, on shoestring budgets find it most difficult to dole out one big payment in stretched out over a period of months. One of my constituents last summer wrote about this problem. I would like to read a brief exerpt from this letter:

"As you can see from the enclosed notice, I bought a wheelchair on 30 September 1976 from Abbey Rents, Inc., for which I paid $147.50. Medicare B has informed me that they will reimburse me for the entire cost of the wheelchair, but that the reimbursement will be on the basis of monthly installments. Social Security laws require such a reimbursement to be made in installments. *** my difficulty is that I had to pay Abbey Rents the entire amount, but that I will be reimbursed in 'dribbles'. My total monthly income is $332.40 paid as Disability Insurance by Social Security; the wheelchair cost over one-third of my total income. It was difficult for me to pay that cost then; it will be even more difficult for me to absorb that cost if I must do it in small installments, especially now that Thanksgiving and Christmas are approaching."

Along these lines, GAO concluded that, when the beneficiaries (rather than the carriers) decide whether to rent or purchase durable medical equipment, they often rent even though anticipated periods of need are long enough to justify purchase.

To correct the potential for abuse in this pay out system, I have introduced H.R. 3296, a bill which simply authorizes the Secretary to make a determination on the basis of medical and other evidence, as to whether purchase of the equipment would be less costly than rental. If such a determination is made, the Secretary may then authorize purchase on a lease-purchase or lump-sum payment basis.

The bill also provides an incentive to purchase used equipment by waiving the 20 percent coinsurance amount whenever the purchase price of the equipment is at least 25% less than thet reasonable charge for comparable new equipment.

Finally, the Secretary is authorized to encourage suppliers of durable medical equipment to make such equipment available on a lease-purchase basis whenever possible.

I am, of course, concerned that beneficiaries should not be delayed in acquiring equipment when it is medically necessary. Often, equipment is acquired before a rent-versus-purchase decision is made. In this regard, I would like to point out that 82% of the insurance carriers (19 of 23) interviewed by GAO allow the first month's rental of an item to be applied toward its purchase price. GAO concluded that "***rent-versus-purchase decisions for equipment acquired from those suppliers would have to be made at the time of acquisition but could be made within the first rental month, to permit exercise of the purchase option is warranted."

I hope that this distinguished Committee will give very serious consideration to making more flexible the present method of reimbursing Medicare recipients for durable medical equipment. This would serve both the interests of economy and certain hardship cases where beneficiaries can not afford to be reimbursed for purchase in small monthly amounts.

Again, I thank the Committee for giving me this opportunity to discuss the problem of rental abuses in the Medicare program.

Mr. Rogers. Thank you very much, Mr. Steers, for being here and letting us have the benefit of your experience.

Chairman Rostenkowski?

Mr. Rostenkowski. I would like to associate myself with the remarks of Chairman Rogers. I know how hard our colleague worked with our staff putting together this legislation. I think it is certainly worthwhile. I am sure we will look at this potential amendment in depth.

Mr. Steers. Thank you, sir.

Mr. Rogers. Dr. Carter?

Mr. Carter. Thank you, Mr. Chairman.

I want to compliment the distinguished gentlemen on his testimony. I feel that it is certainly a worthwhile proposal which would save our Government perhaps millions of dollars each year if we took advantage of it. There's no question that in many cases we know that social security recipients will need this equipment for more than 1 year and for more than the length of time which would be required to pay for the equipment. You have a wonderful idea and I would like to see it implemented.

Mr. Rogers. Mr. Duncan?

Mr. Duncan. I have no questions. I do want to thank our colleague for being here and for his grasp of the situation as we find it today.

Mr. Steers. It is my assistant's grasp that enabled me to be here this morning.

Mr. Duncan. It will be most helpful to us in formulating legislation. We do thank you for your contribution.

Mr. Rogers. Mr. Ford?

Mr. Ford. Mr. Chairman, I don't have any questions. I would, however, like to associate myself with the excellent observations made by our distinguished colleague this morning. I would also like to say thank you for that fine statement before this joint commitee.

Mr. Rogers. Thank you. Mr. Martin?

Mr. Martin. No questions.

Mr. Chairman, I, too, want to commend our colleague for the grasp which his assistant has. [Laughter.]

Mr. Steers. I think for the record, this is Ms. Bobbi Avancena. That is right, it is her grasp. I am her mouthpiece this morning. [Laughter.]

Mr. Martin. I am grateful to you for sharing all this with us.

Mr. Rogers. Ms. Avancena, the committee welcomes you. We are pleased to have had the testimony of the Congressman.

Mr. Steers. Thank you again.

Mr. Rogers. Thank you for your presence here.

The next witness will be the Honorable Manual Carballo, Secretary, Wisconsin Department of Health and Social Services, and representing also the Governors' Conference. Also, I think, there was to be a panel presentation at this time. He will be joined by Gerald Reilly, Director of Medicaid, New Jersey Department of Human Services.

Your statements will be placed in the record in full. Welcome to the committee.

A PANEL CONSISTING OF MANUEL CARBALLO, SECRETARY, WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES, AND ALSO ON BEHALF OF THE NATIONAL GOVERNORS' CONFERENCE; AND GERALD REILLY, DIRECTOR OF MEDICAID, NEW JERSEY DEPARTMENT OF HUMAN SERVICES

Mr. Carballo. Thank you, Mr. Chairman. In light of the fact that the statement will be in the record, I would basically highlight it in order to save the time of the committee.

Mr. Rogers. That would be helpful.

STATEMENT OF MANUEL CARBALLO

Mr. Carballo. First, it is important to state that we heartily applaud the overall intent and objective of H.R. 3. We must tighten up the laws relevant to fraud and abuse in the medicaid and medicare areas. We must make it decidely painful for those who participate in such activities.

There are two aspects of H.R. 3 in particular, however, that raise a certain amount of concern from the point of view of the States. Even in Wisconsin where we are relatively speaking—and I do say relatively speaking—free of the type of abuse that has characterized some of the medicaid programs on other jurisdictions, we feel that the changes in the provisions in the law which make tighter penalties in the area of fraud are essential and necessary. We do feel, howver, that it is essential and desirable to distinguish between fraud and abuse in the language of the bill; and also in our conception of the problems that we face.

The problem of abuse is one which is one of considerably more difficulty than the problem of fraud in many respects since it involves as it does, difficult judgments of professional propriety and adequacy of medical care.

Fraud, on the other hand, although perhaps difficult to prove on different occasions can be a relatively clear area with which to deal.

We feel, however, that the area of abuse is one of concern. Wisconsin, like other States, is identified, albeit belatedly, with what should be considered fraudulent and abusive practice in its medicare program. However, also like other States, Wisconsin has found itself limited in its ability to effectuate curbs of those practices. Both our State legislation as well as Federal statutes have not been sufficently detailed as to what constitutes fraud and abuse in the delivery of health care facilities as to fascilitate legal remedies. Where systems concerning payment for an accounting expenditures are sloppy and poorly defined, difficult in a court action. This is especially a problem as is related to abuse as contrasted with fraud.

The department of health and social services in Wisconsin has been involved in an extensive review of its management practices. This work has identified that our department lacks the requisite data for identifying service utilization patterns; and the reasons why these patterns have developed during the 10-year period of our program. This type of information is accumulated primarily through the claims processing activities which results when a service is rendered and a claim is submitted for payment by the particular health care professional. It is in this area of health care utilization that the most difficult problems involving both intention as well as unintentional abusive practice exists in my judgment. To address this kind of problem, a State must avail itself of appropriate service monitoring criteria and apply them rigorously to its medicaid program. This activity must in turn include a formal linkage with health care professionals whose input and judgment are essential to determining what constitutes appropriate health care.

I would accordingly urge the Congress to consider not only legislation such as H.R. 3 which does address the need for stronger and more well-defined statutes pertaining to fraud, but also the more complex problems of how Governments can effectively interact with health care professionals in defining what consistitutes appropriate health care and in instituting appropriate health control measures so care does not continue to interrupt both the State and Federal budgets.

In terms of this latter point, I would specifically suggest the development of legislation providing even more funding for the development and installation not only of medicaid management information systems among the States, but also uniform accounting systems, shared data with medicare and Champus, common registries of providers, and more. Without fundamental data concerning the health care practices in a State, effective action to counteract both fraudulent and abusive practice cannot be achieved.

I must quickly add that none of us believe that the MMIS will constitute either a panacea or a magic wand. Indeed, it is typical of our modern computer-mania that we will invest millions in data systems—at 75 percent Federal participation for MMIS—but skimp on the foot solders—the auditors and investigators—who must go into the foxholes and convert the computer printouts in recoupment actions and indictments.

We also need to do traditional time-consuming, foot-slogging, eye-wearing and skillful investigative work. In Wisconsin, we have had only four persons assigned to this task in our Wisconsin agency—but I have requested in our current budget proposal an additional twelve and a half positions, a good portion of which will be directed to fraud-abuse investigative work. We consider this amount our highest priorities, and I hope you will assist us with adequate funding so that we can carry out a truly effective and sustained detection and prosecution program. Funds both for training and for operations are required so that our mutual goals can be reached. Certainly the current 50 percent Federal match is inadequate to that end. An optimum program requires skilled professionals, that is experienced and motivated auditors who can effectively deal with and master complicated and sophisticated financial and accounting matrices. We want to do our share of the job fully and professionally, but in our own way and with our own tools, since we know our State better than anyone else. But we need your financial aid.

It is only with actual manpower in the field that we can go into the area of abuse and convert the needs into actions.

The second area of concern with regard to this bill is the role placed in the hands of the professional standard review organizations, PSRO's. For example, section 1158 flatly states that a determination made by a PSRO in the course of its review responsibility shall constitute the conclusive determination for purposes of payment, and effectively forbids any reviews by State agencies for purpose of payment. Yet State dollars are involved—but still the State is forbidden to take any roles in a review system which is dominated solely by those who provide services.

I feel it is improper, if not unconstitutional, that a nongovernmental agency should have the authority to tell State government how to spend their dollars. This is especially the case to the degree that PSRO's preempt the exercise of police powers reserved to the States by the Tenth Amendment. PSRO's are not the most appropriate vehicles to be carrying out such critical functions, and they must not be established as the exclusive actors on this scene.

Greater flexibility is required in the area of State agency/PSRO interface. The full value of the PSRO has not yet been determined, nor has its cost-effectiveness yet been proven. I would suggest that it is premature to give expanded authority to PSRO's until we have gained more experience in working with them and have had full opportunity to assess and evaluate their activity and accomplishments.

In summary, I believe that a real amendment of the PSRO legislation is in order—amendments which would place evaluation of medical care, particularly the function of profile analysis and medical care evaluation studies, into the hands of an independent and interdisciplinary group of professionals, funded and certified by the Government. That broader issue is not before us here, however.

Let me conclude my remarks by thanking you for the opportunity to share my reflections and beliefs—and those of the National Governors Conference with you. It has been a welcomed opportunity, as well as a privilege.

[The prepared statement follows:]

STATEMENT OF MANUEL CARBALLO, SECRETARY, WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Mr. Chairman and honorable committee members. I welcome the opportunity to appear before your two subcommittees today and I consider it a distinct privilege to participate in these hearings.

In testifying before you today, I am wearing two hats—my own and that of the National Governors Conference which asked me to represent them here. Our two sets of views on the Medicare-Medicaid fraud and abuse issue are essentially similar, and accordingly the thoughts and reflections I share with you today are jointely supported ones.

Let me say right away, that I heartedly applaud the overall intent and objective of HR 3. We must tighten up the laws relevant to fraud and abuse in the Medicare-Medicaid area, and we must make it decidely painful for those who participate in such activities. The overall thrust and purpose of HR 3 is in that sense, welcome music to our ears.

There are two aspects of HR 3, however, which do give me cause for some concern and uneasiness. The first portion of my remarks relate to the thoughtful and well intentioned sections of HR 3 which establish mechanisms and procedures to unearth and discover the "bad actors" in the Medicaid-Medicare fraud arena and to more severly punish them once identified.

Even in Wisconsin, where we are relatively free of such problems, we would be the first to support such initiatives, but I would add a caveat to that applause—"don't try to do it all on your own." Please bring in the states from the very beginning as real partners in that critical effort. I am somewhat uneasy at the overall emphasis if not dominance of the federal actors in HR 3—even as to Medicaid issues. We wish to participate with you in an alliance against Medicaid fraud and abuse. Joint federal and state efforts have been successful against organized crime and the narcotics trade. Similar cooperative efforts are needed here. But please remember too that when you seal that partnership with us, detection and enforcement statutes are merely rhetoric of the financial resources to go the job—at either the state or federal levels—are lacking.

May I raise one sub-theme which I believe merits your attention? I feel it would be particularly useful if clear distinctions are drawn in the statutes as between what constitutes fraud and what constitutes abuse. All too often the media—and even professionals—merge the two in their parlance so that they become inter-changeable in the public mind. Headlined stories shouting of Medicaid Fraud" often turn out on close reading of the story to concern a case of abuse.

While we're all obviously "against them both," we nevertheless have a duty to ourselves and to the public to make the distinction and articulate the differences. There should perhaps be sharper language introduced into HR 3, maybe in a definitional sub-section, which sets out the specific facts of each. Since the Act's title includes the words "fraud" and "abuse," it should be subsequently spelled out very clearly in the text when we are talking of fraud and when we are talking about abuse. Abuse is most often a subjective issue, on which frequently turns on professional judgment. Is a patient who sees three doctors simply "diagnosis shopping"—or is he really searching for what he considers quality treatment? Does the physician who prescribes a large quantity of medicine to an individual really believe such a sustained dosage is required? Ad infinitum. Let us define for ourselves and the public by telling them in the statue—in clear terms—how we distinguish between fraud and abuse.

Having said that, let me share with you for a minute or so some of my experiences in Wisconsin as to the Medicaid fraud and abuse issue and why I welcome Federal statutory initiative which not only have a "bite", but which also can deliver the "buck."

Wisconsin, like other states, has identified albeit belatedly what should be considered fraudulent and abusive practice in its Medicaid Program. However, also like other states, Wisconsin has found itself limited in its ability to initiate effective remedies for these current practices or controls to curb future activities of a similar nature.

Both our state legislation, as well as the federal statutes, have not been sufficiently detailed concerning what constitutes fraud and abuse in the delivery of health care services so as to facilitate legal remedies. Where systems concerning payment for and accounting of expenditures are sloppy and poorly defined, the need to prove intent to defraud becomes extremely difficult in a court action.

This is especially a problem as related to abuse, as contrasted with fraud. Under my direction, the Wisconsin Department of Health and Social Services has been involved with an extensive review of its management practices in directing our state program. This work has identified that the Department lacks the requisite data for identifying service utilization patterns and the reasons why these patterns have developed during the 10-year period of our program. This type of information is accumulated primarily through the claims processing activities which result when a service is rendered and a claim is submitted for payment by the particular health care professional. It is in this area of health care utilization where the most difficult problems involving both intentioned, as well as unintentioned, abuse of practice exists in my judgment. To address this kind of problem a state must avail itself of appropriate service monitoring criteria and apply them rigorously to its Medicaid Program; this activity must include a formal linkage with health care professional whose input and professional judgment are essential in determining what constitutes appropriate health care.

I would accordingly urge the Congress to consider not only legislation such as HR 3, which does address the need for stronger and more well-defined statutes pertaining to fraud, but also the more complex problems of how governments can effectively interact with health care professionals in defining what constitutes appropriate health care and in instituting appropriate cost control measures so that care does not continue to bankrupt both state and federal budgets. In terms of this latter point, I would specifically suggest the development of legislation providing even more funding for the development and installation only only of Medicaid Management Information Systems among the states, but also uniform accounting sytsems, shared data with Medicare and Champus, common registries of providers and more. Without fundamental data concerning the health care practices in a state, effective action to counteract both fraudulent and abusive practice cannot be achieved. Such legislation must also include appropriate directives to the federal bureaucracy concerning the need to provide some latitude for regional differences in the practice of medicine and the need for the federal bureaucracy to clearly identify those differences and what policy impact these have for the federal Medicaid Program.

Having said the above, I must quickly add that none of us believe that the MMIS will constitute either a panacea or a magic wand. Indeed, it is typical of our modern computermania that we will invest millions in data systems (at 75% Federal participation for MMIS) but skimp on the foot soldiers—the auditors and investigators—who must go into the foxholes and convert the computer print-outs in recoupment actions and indictments. We also need to do traditional, time consuming, foot slogging, eye-wearying and skillful investigative work. We have had only four persons assigned to this task in our Wisconsin agency—but I have requested in our current budget proposal an additional 12½ positions, a good portion of which will be directed to fraud-abuse investigative work. We consider this among our highest priorities and I hope you will assist us with adequate funding so that we can carry out a truly effective and sustained detection and prosecution program. Funds both for training and for operations are required so that our mutual goals can be reached. Certainly the current 50% federal match is inadequate to that end. An optimum program requires skilled professionals, e.g., experienced and motivated auditors who can effectively deal with and master complicated and sophisticated financial and accounting matrices. We want to do our share of the job fully and professionally, but in our own way and with our own tools, since we know our state better than anyone else. But we need your financial aid.

The second issue relates to the expanded role and powers of the PSROs as envisaged in this Bill. For example, section 1158 flatly states that a determination made by a PSRO, in the course of its review responsibility, shall constitute the conclusive determination for purposes of payment, and effectively forbids any review by state agencies for purpose of payment. Yet state dollars are involved—but still the state is forbidden to take any role in a review system which is dominated solely by those who provide services. At the same time that the state is forbidden to do any reviews for payment purposes, the monitoring of PSROs that the state may perform is at the pleasure of the Secretary, who "may arrange to have * * * State agencies assist him in monitoring." (This language from the recently issued regulation for P.L. 92-603).

I feel it is improper, if not unconstitutional, that a non-governmental agency should have the authority to tell state government how to spend their dollars. This is especially the case to the degree that PSROs preempt the exercise of police powers reserved to the states by the Tenth Amendment. PSROs are not the most appropriate vehicles to be carrying out such critical functions and they must not be established as the exclusive actors on this scene.

Greater flexibility is required in the area of state agency/PSRO interface. The full value of the PSRO has not yet been determined, nor has its cost effectiveness been yet proven. I would suggest that it is premature to give expanded authority to PSROs until we have gained more experience in working with them and have had full opportunity to assess and evaluate their activity and accomplishments.

It strikes me that there is something inherently unstable in a scenario which has as one actor, a state operating under tight fiscal constraints, and as the other actor, a non-governmental group with the power of increasing the state's financial liability. Somehow we must modify the state-PSRO tandem to permit some degree of state control with concomitant PSRO accountability to the state. Perhaps a contract relationship can be evolved which can strike the proper balance. But in any event, a state cannot be put in the position of the wagged tail. We feel it is inappropriate for PSROs to be the sole arbiters of the quality and necessity of medical care.

At the same time we are not unmindful of the recognition which HR 3 gives to the necessity for a PSRO to share data and information with state agencies relevant to its findings with respect to suspected cases or patterns of fraud and abuse.

We welcome the language of this new proposed Section 1166 and would eagerly utilize it. We do have some special thoughts on the second portion of 1166 section (b)(2) which permits aggregate statistical data to be shared with State Health Planning Agencies. While the amendment moves in the direction we would like, it does not go far enough. As presently written, the amendment would have PSROs give aggregate data, including hospital-identified data, to state and Federal agencies. But the aggregate data may not be analyzable in the way in which a state of federal agency would wish. We would recommend adding a sentence at the end of Section 1166 (b)(2) to read: "Such state agencies shall have the option of receiving machine readable patient or discharge records (excluding the individual patient identifiers), and including hospital indentification, for the purposes of comparative analyses and evaluation."

We are also concerned that the language of the disclosure amendment in sub-section (c) made absolutely unambiguous about the application of penalties for disclosure of information relating to cases of patterns of fraud or abuse. We wonder whether, for example, an HSA or State Planning Agency which had received aggregate data on an individual hospital which came under suit, would become subject to the penalties of the law. If such an interpretation could be made, the language should be clarified to prevent it.

In summary, I believe that a real amendment of the PSRO legislation is in order—amendments which would place evaluation of medical care, particularly the function of profile analysis and medical care evaluation studies, into the hands of an independent and interdisciplinary group of professionals, funded and certified by the government. That broader issue is not before us here, however.

Let me conclude my remarks by thanking you for the opportunity to share my reflections and beliefs—and those of the National Governors Conference—with you. It has been a welcomed opportunity, as well as a privilege. I want you to know that we in Wisconsin and in the Conference feel very strongly that Medicare-Medicaid abuse and fraud must be addressed comprehensively, dealth with aggressively and persistently, and tolerated not at all. We are committed to that goal. We feel that the states must be active partners with the Federal Government in that effort, deploying and utilizing our indigenous assets as we deem most appropriate. But to do the job we must do, we must rely on your Federal partner and ally to give us the wherewithal.

Thank you.

Mr. Reilly has a brief statement as well.

Mr. Rogers. Mr. Reilly?

STATEMENT OF GERALD REILLY

Mr. Reilly. Thank you for the opportunity to offer the views of the New Jersey Department of Human Services on these amendments.

The provision of needed health services to the poor people of our country is the humane and worthwhile goal for which the medical assistance program was created by the Congress. The continued pursuit of this goal will be seriously harmed unless we are able to assure the public that we can effectively manage the program and keep to an irreducible minimum abusive and fraudulent practices. We see the thrust of H.R. 3 to be consistent with this urgent need, and, therefore, wish to offer support to your initiative.

There are two areas of concern, however, that we wish to raise for your consideraation. The first is that H.R. 3 does not address itself sufficient to two of the most fundamental problems facing the medical assistance program, which are management deficiencies, at both the State and Federal levels, and the lack of appropriate provider reimbursement systems.

H.R. 3 deals mostly with developing better methods of dealing with abuse and fraud after their discovery, and does not focus on developing a tight, well-organized system leading to a climate of compliance that will prevent, or it least minimize, abuse and fraud. We recognize that you are fully aware that H.R. 3 is merely a first step, but wish to strongly emphasize that the necessary next steps, many of which were outlined last year in S. 3205 must be taken quickly. Our hope is that H.R. 3, once enacted, will serve to increase the momentum for more fundamental reform.

Our second major concern with H.R. 3 is its heavy reliance upon the PSRO concept. We are concerned that the Congress may be overestimating the competency of professional standards review organizations in controlling fraud and abuse. In New Jersey, we have eight PSRO's, each at different stages of development, and each at different levels of effectiveness. Three are at an advanced level of development and we have signed memorandums of understanding with them. At the other end of the spectrum, we have one PSRO that recently dissolved itself, and is starting over. It would not be an exaggeration to point out that our State medical assistance program in New Jersey—and I think in many other States—after 7 years of experience and a reasonably good track record, may be somewhat more effective at monitoring and controlling the expenditure of State and Federal medicaid dollars than eight provider-governed organizations, at least for the near future.

We do agree that changes need to be made in the statutes governing PSRO's, but would suggest that they be deleted from this important piece of legislation and be considered in a separate measure. If such separation is not possible, we strongly urge that amendments be considered to modify the unlimited grant of authority now given to PSRO's over the expenditure of public funds.

The final authority as to necessity and appropriateness of care should reside with public agencies, since public funds are being expended. We do see a constructive role for PSRO's in making such decisions, but as a partner, not as a final arbiter. We think it is possible to work out an arrangement that will maintain many of the potential benefits of well-run PSRO's while, at the same time, restoring appropriate public oversight.

I would like to commend to your attention the recent report of the National Governors Conference on Medicaid Reform which receive the nearly unanimous support of the Governors of 50 States which I believe has been provided to the staff. Many of the recommendations in this report bear directly on H.R. 3 and many others bear on far more fundamental reforms on the medical assistance program. This report was put together by a group of some of the most knowledgeable people in the country through the entire Nation and warrants your serious consideration.

I would like to thank you for this opportunity to share a few of our thoughts on these very complicated issues. Any further assistance New Jersey can provide to you on these matters will be gladly offered. We commend your work in this very important effort to restore public confidence in the medicaid and medicare programs.

Thank you.

Mr. Rogers. Thank you very much.

Chairman Rostenkowski?

Mr. Rostenkowski. I have no questions, thank you Mr. Chairman.

Mr. Rogers. Mr. Ottinger?

Mr. Ottinger. I have no questions, Thank you Mr. Chairman.

Mr. Rogers. Dr. Carter?

Mr. Carter. Thank you, Mr. Chairman.

I think the gentlemen have brought some things to the attention of this committee that will be very helpful. I believe you in particular would like to involve the States more. Of course, you would like to have Federal funding for that, as I would see it. I understand that you are fearful of PSRO's being involved. I don't know that whether providers particularly want to be involved in this area. You have mentioned abuse. How would you find out about the abuses with assistance from professionals in the health field?

Mr. Carballo. If I may answer, at least on behalf of Wisconsin, there is no question that the judgment as to medical necessity is one that is properly in the hands of professionals. The question is under what circumstances are the professionals used?

In the case of the Wisconsin Department of Health and Social Services, we have an umbrella agency which includes a Division of Health and has within it many of the same types of professionals that are available through other means. Professionals can be on the public payroll. Professionals can be in a nonprofit corporation. We do not question at this point the effectiveness of efficiency of PSRO's. It is too early to tell.

We are concerned, however, that as organizations which are essentially dominated by professionals, with no public accountability to States who pay at least in our case a substantial portion of the Medicaid bill that the consequences of their decisions extend beyond the ordinary judgment of professional practice.

Therefore, we would like to see a greater cooperative effort between the States and the PSRO's to see what can be done to make use of their skills.

Mr. Carter. Thank you. I believe you expressed on one page of your testimony the term "appropriate health care." I would like you to define appropriate health care, if you please?

Mr. Carballo. Obviously appropriate can be taken in two ways. One is the issue of professional judgment, as to what constitutes the appropriate treatment for any given ailment. The other is what do we feel we can afford and what ought to be included within a health related program such as medicaid. We would say that the defiinition of the term such as appropriate health care requires a lot more time than we would have to present at this committee. It is a subject that would have to proceed through a definition of every area of the human condition.

The World Health Organization's definition of good health, or of health care, says that it is a state of well-being in a social, economic, and physical as well as mental health. That, obviously, is a definition which encompasses about two-thirds of the universe, if not all of it; so appropriate health care is an area upon which professionals disagree.

I am sure public administrators disagree as well.

Mr. Carter. I notice you are including a cost factor into appropriate health care. Of course, we must work within the constraints of what we have; but still I feel that those who are particularly without funds should receive the same care as anyone else.

Thank you for your testimony.

Mr. Rogers. Mr. Duncan.

Mr. Duncan. I have no questions. Thank you, Mr. Chairman.

Mr. Rogers. Mr. Vanik?

Mr. Vanik. No questions.

Mr. Rogers. Mr. Ford?

Mr. Ford. I have no questions, Mr. Chairman.

Mr. Rogers. Mr. Martin?

Mr. Martin. Mr. Carballo, you said that there needs to be an adequate level of Federal funding. Could you tell us what that level would be in your opinion—50 percent apparently is inadequate? I am sure 100 percent would be inadequate. Do you have any other guidance on that?

Mr. Carballo. Well, I think the point here is that the Government—the current legislation does take an enlightened attitude with regard to the development of medicaid management information systems. It does pay there, for instance, for 90 percent of the developmental costs and approximately 75 percent of operations thereafter.

Mr. Martin. Ninety percent of startup and 75 percent of continuing—is that ideal?

Mr. Carballo. Some perhaps would think 100 percent would be ideal. I think a measure of funding which would provide a recognition for the priority to be afforded for employees to take a system like MMIS and convert it into real actions, that that is an appropriate recognition of that priority: 90 percent for startup, 75 percent continuation would certainly be an improvement over the current situation.

Mr. Martin. Does that relate to the priority on the State's point of view as well, 10 percent?

Mr. Carballo. Well, the State—I think it is a high priority within the States under current financial circumstances to do what they can in the area of fraud and abuse. We have had excellent cooperation from our attorney general. We have had excellent cooperation from prosecutorial agencies throughout the State.

The fact is, however, the States are currently under extremely limited fiscal circumstances. The assistance that can be provided through Federal funding would make some things likely to happen faster and more easily than otherwise.

Mr. Martin. The Federal Government certainly is not under limited fiscal circumstances.

What would do on the PSRO review in section 1158? Mr. Reilly says he would delete it. Would you delete it?

Mr. Carballo. Yes, I would.

Mr. Martin. Would you replace it with anything or just leave a void?

Mr. Carballo. I think Mr. Reilly should speak for himself. But I think it is our feeling that the PSRO provisions as a whole should be reviewed and that that should be done quickly, perhaps in separate legislation.

Second——

Mr. Reilly. I agree with that, also.

Mr. Carballo. Second, that type of review can be conducted by the State agency involved.

Mr. Reilly. Mr. Martin, could I respond to your first point?

Mr. Martin. Certainly.

Mr. Reilly. The National Governors Conference Task Force on Medicaid Reform report specifically rejects the notion that a 100-percent Federal funding is ideal and maintains the necessity for a State commitment and a State willingness to put its dollars on the line, if the States believe that the medical assistance program is an appropriate area of State administration. Based upon this report and the Governors' endorsement of it, they do.

We do not see a 100 percent as the ideal. As Mr. Carballo points out, from time to time Federal incentives in the right direction help move States along.

Mr. Martin. I appreciate your further clarification on that. I did want to have that idea on the record. Thank you.

Mr. Rogers. May I say we have heard some testimony to the effect that some of the States have been rather slow to prosecute medicaid fraud and abuse. Would you comment on that?

Mr. Reilly. I think that's probably been true; and in some cases, it had to do with the State's structure wherein prosecution occurred at the local level and data collection in this instance occurred at the State level.

In our State, we are very fortunate in having a discrete unit within the Office of the Attorney General that specializes in the prosecution of medical assistance and fraud.

Mr. Rogers. Does this appear to be changing? Are the States more aware of this now? Are they beginning to set up units for prosecution?

Mr. Reilly. In my opinion, yes.

Mr. Rogers. Could you let us have perhaps a rundown of maybe the Governors Conference——

Mr. Carballo. We could try to determine that.

[The following letter was subsequently received:]

NATIONAL GOVERNORS' CONFERENCE,
March 18, 1977.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on Health and the Environment, Rayburn House Office Building, Washington, D.C.

DEAR REPRESENTATIVE ROGERS: On March 7, Manuel Carballo, Secretary of the Wisconsin Department of Health and Social Services, testified on behalf of the National Governors' Conference voicing our strong support of the intent and objectives of HR 3. As you know, the Governors recently adopted a comprehensive policy position supporting Medicaid reform and recommending that "a comprehensive program for the detection, investigation and prevention of recipient and provider fraud and abuse within the Medicaid program should be developed, with emphasis on improved coordination between Medicaid program integrity personnel and federal, state and local law enforcement agencies."

During Secretary Carballo's appearance before the Joint Committee, you requested that the National Governors' Conference provide information on which States have set up special prosecution units similar to that of New Jersey described by Mr. Riley. Neither the Fraud and Abuse Division of the HEW Medical Services Administration, the Program Evaluation Staff, HEW/SSA Bureau of Health Insurance or the U.S. Justice Department has such information. While your timetable does not allow our staff sufficient time to conduct a special survey of the States, we have learned that the National Association of State Attorneys General has surveyed its membership on this issue and the Association tells us that 46 States have developed internal procedures to address the problem of providers and/or recipients suspected of defrauding or abusing the Medicaid program. In addition, the Association of State Attorneys General reports that eight of those States have established special units of the New Jersey type. These include:

New York—Special State Prosecutor for Nursing Homes, Health and Social Services Fraud;

New Jersey—Legal Action Committee;

Michigan—Medicaid Program Integrity Division;

California—Surveillance and Utilization Review Project, Department of Health;

Ohio—Attorney General's Unit within Social Services Department;

South Carolina—Established procedure for involvement for Attorney General or U.S. Attorney;

Texas—White Collar Consumer Fraud Unit;

Minnesota—Medicaid Public Integrity Division in Coordination with Attorney General's Office.

While the methods chosen vary from State to State, I am convinced that the vast majority have a firm commitment to a coordinated and effective attack on fraud and abuse. They will succeed, however, only if they are allowed to use other methods best suited to the administrative and legal condition in their own States.

We appreciate the willingness of Congress to strengthen the safeguards against fraud and certainly would be glad to provide the Committee with any additional information concerning state efforts in this area.

Sincerely,

GEORGE BUSBEE,
Governor of Georgia,
NGC Task Force on Medicaid Reform.

Mr. ROGERS. Also let me just ask this: It's been proposed, and you have already discussed, that there be a higher Federal contribution for this purpose. Along with that would there be a need for a separate agency outside of medicaid. What would be your reaction to that?

Mr. CARBALLO. To have an investigative unit outside of medicaid?

Mr. ROGERS. Yes. In other words, separate from the adminisrative units of medicaid.

Mr. Carballo. Mr. Reilly would like to comment. I will add remarks.

Mr. Reilly. I think you are referring to the amendment proposed by Mr. Scheuer. We think parts of his amendment are excellent. In New Jersey, we currently do what he suggests, but we do it in two pieces.

The medical assistance program operates the front-end surveillance, the surveillance and utilization review system. The Attorney General's Office prosecutes. We think we do better claims processing and data management, and we think they are better at prosecuting. We would oppose the idea of mandating a distinct entity.

Perhaps it could be permissive. It might work in some States. In our State it works better with the prosecutors prosecuting and the managers managing.

Mr. Rogers. Yes.

Mr. Carter. I thank the Chairman for yielding.

Since you mentioned the great Garden State of New Jersey, I understand that even your State has problems and that approximately 17 laboratories in your State do about 70 percent of the laboratory work; is that correct?

Mr. Reilly. I don't think that is correct any longer.

Mr. Carter. I trust you are developing a model system. But I feel that ther's going to have to be Federal input into this.

Gentlemen, someone spoke about appropriate health care, and gave us a definition of it. Actually, if we get down to that, I believe it should include prenatal care, delivery, postnatal care, preventive care with health education, immunization; of course, periodic examinations; medical and surgical care when necessary for accidents, and illnesses; and also care for catastrophic illnesses. At least those are the main elements of the definition I have supported.

Thank you, Mr. Chairman.

Mr. Rogers. One last question.

Mr. Rostenkowski. I just wanted to know from Mr. Reilly how long has this cooperative effort that you displayed in New Jersey been in existence? When was it first felt that there was a need for such a unit?

Mr. Reilly. Well, about 2 years ago, 2½–2 years ago. We had always had a relationship with the Attorney General and a good relationship where they were interested in prosecuting medicaid fraud. We had had a number of convictions prior to 1975; but in the beginning of 1975, we saw the need to develop a specialized unit within the Attorney General's Office to prosecute and investigate these cases; because they are very difficult, technical cases. In the day-to-day priorities of many prosecutors' offices, other things may tend to come first. Crimes of a more violent nature. We found that by having a special unit which is now left to, I believe, nine people who really do nothing but specialize in this, they developed an expertise. They know how to build these cases. They know how to go through the paper. They know how to use computer applications and computer systems to assist through thousands of claims. It has been very successful. I think——

Mr. Rostenkowski. They recognize patterns as they are created?

Mr. Reilly. Yes.

Mr. Rostenkowski. How many people does the Attorney General have on his staff, approximately; do you know?

Mr. Reilly. The Attorney General's unit has about nine people right now. We in the division have about 70 people involved in all aspects of program integrity. They are the front end of the funnel. They sift through the initial information and begin to develop cases that are potential. Then they are discussed with representatives of the Attorney General's office and they determine whether to take them on for further indepth investigation or not.

Mr. Rostenkowski. Thank you.

Mr. Rogers. Let me just ask this: Why is it you think that it is felt that incentives need to be given to States to prosecute? It's in their best interests to do so because you would also be recovering State money as well as Federal?

Mr. Carballo. I think the answer is not so much a need for incentives, because there is an existing will to do the job. The issue is the resources.

As you know, sir, many States operate for instance on biennial budgets, a decision that is made now can't be funded unless there is some Federal funds on some later schedule.

I think it's a matter providing some resources to get the States actively pursuing this area. That is a precedent that has been established in the MMIS area. I think it is quite reasonable to extend it to this area which in many respects is nothing more than the application of the data that a system such as MMIS will be generating.

It is, in effect, a development to assure that the previous Federal development in rather complex data systems yields the benefits it was intended to yield.

Mr. Rogers. Would you anticipate that this money would go into data assembling?

Mr. Carballo. To take an example——

Mr. Rogers. Or in prosecuting, or in going toward quality?

Mr. Carballo. I think to take in example, a good data system and a good system will indicate that there are deviations in norms. It will say that a particular physician is performing 300 percent more hysterectomies than most other people in a particular area; that may or may not be an abuse. That may or may not involve fraud. What is needed is for somebody to go out there and to investigate that situation and come back and say, this looks like a situation that warrants further investigation.

That is the kind of activity that I am talking about financing. You can have all the printouts in the world but unless you have somebody to go out there and look at the facts and look at the specific situation, you cannot build a case; and what we are talking about here is the assembling of the facts and the assembling of judgment where necessary that indicates that it is appropriate to proceed to the next step which in our case would be referral to the Attorney General for prosecution.

Mr. Rogers. Thank you very much, Mr. Carballo. Thank you, Mr. Reilly. The committee is grateful for your presence here today.

The next witness will be Robert B. Fiske, Jr., U.S. attorney, Southern District of New York.

I understand he will be accompanied by George Wilson, assistant U.S. attorney.

STATEMENT OF ROBERT B. FISKE, JR., U.S. ATTORNEY, SOUTHERN DISTRICT OF NEW YORK, ACCOMPANIED BY GEORGE WILSON, ASSISTANT U.S. ATTORNEY

Mr. FISKE. Thank you, sir.

Mr. ROGERS. Thank you for taking the time to appear here today. Do you have a prepared statement?

Mr. FISKE. Yes, we do. Mr. Rogers will make those copies available.

Mr. ROGERS. Thank you. Your prepared statement will be made a part of the record.

Mr. ROGERS. You may proceed as you desire.

Mr. FISKE. Mr. Chairman, members of the committee, my name is Robert B. Fiske, Jr. I am the U.S. attorney for the southern district of New York. I am very pleased to have this opportunity to appear before you today. With me is Assistant U.S. Attorney George E. Wilson, the chief of our health and welfare fraud unit. George has been primarily responsible for the medicaid investigations and criminal prosecutions conducted by our office.

For the past 4 years, our office has been involved in an intensive investigation of fraudulent medicaid claims in the metropolitan New York City area.

These submissions were made by physicians, other medical practitioners, and laboratories. Most of the medicaid practitioners practiced in shared health facilities, the worst of which are more commonly referred to as medicaid mills. Today, we have convicted a total of 25 medical doctors, podiatrists and chiropractors, plus 6 nonprofessional defendants on a total of 152 felony counts.

They were found guilty of violating U.S. criminal code sections involving the crimes of conspiracy to defraud the United States, mail fraud, false statements to the United States, false claims against the United States, income tax evasion and the filing of false tax returns.

In addition, two chiropractors and three medical laboratory operators are currently under indictment. We have brought civil actions, under the Federal False Claims Act against the defendants who have been convicted.

I would say this is a very important part of our program against medicaid fraud where we not only attempt to obtain criminal convictions against those violating the criminal laws, but once we obtained those convictions, we seek to use the penalty provisions of the False Claims Act to recover back for the Federal Government double the amount the Federal Government has paid, plus an extra amount under the penalty provisions which to date we feel has roughly covered the cost of the investigation that we have made.

To date, we have obtained civil settlements totaling over $600,000, which as I said a minute ago, amount to double the amount paid out by the Federal Government on the falso medicaid claims, plus an additional amount sufficient to roughly cover the cost of our investigation.

We believe the State and the city of New York should be able to recover a similar amount. We have put procedures into effect with the State and the city whereby they will be able to bring their own civil actions at the same time we bring ours on any medicaid convictions we obtain in the future.

We have currently underway a continuing—and ever expanding grand jury investigation—into medicaid fraud. While it is obviously inappropriate to comment specifically, it is fair to say that we expect a number of further indictments in the near future.

Our experience in the investigations completed and those still underway lead us to conclude that, due to enormous number of claims which had to be reviewed, the only way to adequately conduct these reviews was through computer profiling.

Until 6 months ago, there were no profiles available for criminal investigative purposes. In the early stages of our investigation, we had to start with city computer tapes, find funds, a programer and computer time to perform our task.

HEW provided the funds and a computer expert. Eventually, we secured access to a U.S. Army computer at Fort Monmouth, N.J. GSA and HEW furnished computer programing services. Working with the programer, we designed our own profiles. The State of New York Department of Social Services is now developing computer profiles which are valuable in criminal investigations. However, patient profiles, which have yet to be developed, are still needed for a really effective means of ferreting out fraudulent practices.

One of the biggest problems with the whole medicaid program is that it has an insufficient number of investigators and auditors who can conduct large-scale criminal investigations into medicaid fraud. We needed investigators and auditors for our investigations and sought assistance from the Department of Health, Education, and Welfare.

After a great deal of difficulty, a variety of untrained personnel were detailed to us who we trained as investigators. We were fortunate to be allowed to hire through the Office of Investigation of HEW as temporary staff four recently graduated college students at the GS–5 level.

None had any previous background or experience as either investigators or auditors, but all were bright and highly motivated. After a period of apprenticeship the two who did not leave our investigation for permanent positions in other Government agencies, developed into outstanding medicaid investigators.

Two other HEW GS–7 staff members, one from the region II SRS staff and one from its audit agency, have been allowed to remain on our investigating staff for approximately 2 years, thanks to the generosity of HEW, region II SRS Commissioner Bill Tobey and region II Audit Manager Bernard Luger. They also have developed into outstanding medicaid investigators. We have been most successful with auditors or personnel who had previous auditing experience.

In the past 6 months, we obtained assistance from the IRS. However, their assistance has been very limited.

As noted earlier, there is a critical need for a professional criminal investigative staff within HEW to assist the FBI and U.S. attorneys in developing criminal cases. Although the FBI began investigating medicaid fraud last fall, the average special agent does not have the required knowledge of the workings of two complex programs—the Federal and State—nor should he be expected to as he is a generalist responsible for investigating virtually every crime in the book. It is here that the specially-trained HEW investigator/auditor can supplement an investigation.

The ideal investigator, while having a thorough understanding of every aspect of the Federal and State program, should be well-versed in auditing or paramedical skills. Working as teams, this mix of skills is ideally suited for medicaid fraud investigations. Most patient witnesses are from the lower socioeconomic strata and many speak no English.

Mr. Rogers. Don't try to speak if you are choking. Maybe Mr. Wilson can speak for you.

Mr. Wilson. Since the majority of them are women, we have found that women investigators are very effective. If our experience with the people we have trained is any indication of what it takes to make a good medicaid investigator, we suggest that the proper approach would be to select people not for their prior police experience but for their skill in accounting or medical technology.

The Bureau of Health Insurance of the Social Security Administration has adopted this approach and has some outstanding investigative-auditors in its New York offices.

There are many deficiencies in the present operations of the medicaid program which make criminal investigation and prosecution difficult at best. H.R. 3 goes far to solve some of the deficiencies.

We firmly support H.R. 3 and have previously submitted to Congressman Rostenkowski our suggestion for improving it. I have appended these suggestions to my statement.

We especially support changing the penal sections of the Social Security Act (1877 and 1909), to upgrade crimes against medicaid and medicare from misdemeanors to felonies. These changes will increase the deterrent effect of these statutes and would also make medicare and medicaid fraud prosecutions more attractive to Federal prosecutors from the standpoint of committing their resources to lengthy investigations.

Existing regulations should be amended and enforced. Patients should be required to sign medicaid invoices at the time the service is rendered. The format of the invoice should be changed to clearly reflect the Federal presence and penalties for fraud. If a number of providers practice together as a clinic or similar organization, the organization should also be licensed.

Finally, there is also, because of the sheer volume of claims submitted, an absolute need for use of computer technology. A medicaid management information system which would provide profiles of clinics, laboratories, providers, and patients, is absolutely essential. It is only through computer technology that program abuse can be detected.

The Bureau of Health Insurance of the Social Security Administration already has such a system for medicare which we feel could be adapted to medicaid by the States.

Mr. ROGERS. Thank you very much.

I understand you have attached to your statement certain changes proposed to this bill. These, too, will be made a part of the record.

Also, the listing of convictions will be made a part of the record.

[The prepared statement and attachment follow:]

STATEMENT OF ROBERT B. FISKE, JR., UNITED STATES ATTORNEY FOR THE SOUTHERN DISTRICT OF NEW YORK

Mr. Chairman and members of the committee, my name is Robert B. Fiske, Jr., and I am the United States Attorney for the Southern District of New York.

I am very pleased to have this opportunity to appear before you today. With me is Assistant United States Attorney George E. Wilson, who is the chief of our Health and Welfare Fraud Unit and has been primarily responsible for the Medicaid investigations and criminal prosecutions conducted by our office.

For the past 4 years, our office has been involved in an intensive investigation of fraudulent Medicaid claims in the Metropolitan New York City area. These submissions were made by physicians, other medical practitioners and laboratories. Most of the Medicaid practitioners practiced in shared health facilities, the worst of which are more commonly referred to as Medicaid Mills.

To date we have convicted a total of 25 medical doctors, podiatrists and chiropractors plus 6 non-professional defendants on a total of 152 felony counts. They were found guilty of violating United States Criminal Code Sections involving the crimes of conspiracy to defraud the United States, mail fraud, false statements to the United States, false claims against the United States, income tax evasion and the filing of false tax returns. In addition, two chiropractors and three medical laboratory operators are currently under indictment. We have brought civil actions, under the Federal False Claims Act against the defendants who have been convicted. To date these have resulted in civil settlements totaling over $600,000, which amounts to double the amount paid out by the Federal Government on the false Medicaid claims, plus an additional amount which was sufficient to roughly cover the cost of our investigations to date. The State and City of New York should be able to recover a similar amount.

We have currently underway a continuing—and ever expanding grand jury investigation—into Medicaid fraud. While it is obviously inappropriate to comment specifically, it is fair to say that we expect a number of further indictments in the near future.

INVESTIGATIVE PROBLEMS

Our experience in the investigations completed and those still under way led us to conclude that, due to enormous number of claims which had to be reviewed, the only way to adequately conduct these reviews was through computer profiling. Until six months ago there were no profiles available for criminal investigative purposes. In the early stages of our investigation we had to start with City computer tapes, find funds, a programmer and computer time to perform our task.

HEW provided the funds and a computer expert. Eventually, we secured access to a United States Army computer at Fort Monmouth, New Jersey. GSA and HEW furnished computer programming services. Working with the programmer, we designed our own profiles. The State of New York Department of Social Services is now developing computer profiles which are valuable in criminal investigations. However, patient profile, which have yet to be developed are still needed for a really effective means of ferreting out fraudulent practices.

One of the biggest problems with the whole Medicaid program is that it has no investigators and auditors who can conduct large-scale criminal investigations into Medicaid fraud. We needed investigators and auditors for our investigations and sought assistance from the Department of Health, Education, and Welfare. After a great deal of difficulty, a variety of untrained personnel were detailed to us who we trained as investigators. We were fortunate to be allowed to hire through the Office of Investigation of HEW as temporary staff four recently graduated college students at the GS-5 level. None had any previous background or experience as either investigators or auditors, but all were bright and highly motivated. After a period of apprenticeship the two who did not our investigation for permanent positions in other Government agencies, developed into outstanding Medicaid investigators. Two other HEW GS–7 staff members, one from the Regiin II S.R.S. staff and one from its Audit Agency, have been allowed to remain on our investigating staff for approximately two years, thanks to the generosity of HEW, Region II S.R.S. Commissioner Bill Tobey and Region II Audit Manager Bernard Luger. They have also developed into outstanding Medicaid investigators. We have been most successful with auditors or personnel who had previous auditing experience.

White collar crime is solved by following vague trails on paper and its solution often does not result from more conventional criminal investigative methods.

As noted earlier, there is a critical need for a professional criminal investigative staff within HEW to assist the FBI and United States Attorneys in developing criminal cases. Although the FBI began investigating Medicaid fraud last fall, the average Special Agent does not have the required knowledge of the workings of two complex programs—the federal and state—nor should he be expected to as he is a generalist responsible for investigating virtually every crime in the book. It is here that the HEW investigator/auditor can supplement an investigation.

The ideal HEW investigator, while having a thorough understanding of every aspect of the federal and state program, should be well-versed in auditing or para-medical skills. Working as teams, this mix of skills is ideally suited for Medicaid fraud investigations. Most patient witnesses are from the lower socio-economic strata and many speak no English. Since the majority of them are women, we have found that women investigators are very effective. If our experience with the people we have trained is any indication of what it takes to make a good Medicaid investigator, we suggest that the proper approach would be to select people not for their prior police experience but for their skill in accounting or medical technology. The Bureau of Health Insurance of the Social Security Administration has adopted this approach and has some outstanding investigative-auditors in its New York office.

There are many deficiencies in the present operations of the Medicaid program which make criminal investigation and prosecution difficult at best. HR–3 goes far to solve some of the deficiencies.

We firmly support HR–3 and have previously submitted to Congressman Rostenkowski our suggestion for improving it. I have appended these suggestions to my statement.

We especially support changing the penal sections of the Social Security Act, (§§ 1877 and 1909[1]), to upgrade crimes against Medicaid and Medicare from misdemeanors to felonies. These changes will increase the deterrent effect of these statutes and would also make Medicare and Medicaid fraud prosecutions more attractive to federal prosecutors from the standpoint of committing their resources to lengthy investigations.

Existing regulations should be amended and enforced. Patients should be required to sign Medicaid invoices at the time the service is rendered. The format of the invoice should be changed to clearly reflect the federal presence and penalties for fraud. If a number of providers practice together as a clinic or similar organization, the organization should also be licensed.

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[1] 42 U.S.C. §§ 1395nn and 1396h.

Finally, there is also, because of the sheer volume of claims submitted, an absolute need for use of computer technology. A Medicaid Management Information System which would provide profiles of clinics, laboratories, providers and patients, is absolutely essential. It is only through computer technology that program abuse can be detected. The Bureau of Health Insurance of the Social Security Administration already has such a system for Medicare which we feel could be adapted to Medicaid by the states.

PROPOSED CHANGES TO H.R. 3

SECTION 3

Page 7, line 25: change "three" to "five."

This would confirm the section to the federal Statute of Limitations for criminal actions. Law enforcement agencies would be able to gain access to records covering the full period of time for potential prosecution.

SECTION 7

On page 29, line 20: after the word "offense" insert: ", in any federal or state court."

This would make it clear that a conviction in any jurisdiction would trigger a suspension in any other jurisdiction.

Page 29, line 25: after the word "appropriate" insert: "except that if the offense is a felony, in the jurisdiction of the conviction, such physician or individual practitioner shall be permanently suspended";

Page 30, line 3: delete the words "during the period" substituting therefor the word "beginning with the effectvie date".

Page 30, line 23: After the word "appropriate;" insert "except that if the offense is a felony in the jurisdiction of the conviction, such physician or individual practitioner shall be permanently suspended;"

Page 31, line 1: delete the words, "during the period", substituting therefor the words "beginning with the effective date".

These changes express our firm view that one who is convicted of a felony arising out of his or her involvement in either the Medicaid or Medicare program should be permanently deprived of participating in any program. This would contribute a needed atmosphere of deterrence which is presently conspicuous by its absence.

SECTION 8

Page 31, line 12: After "owners" insert ", officers, directors, agents, or managing employees".

Page 31, line 22: change "and" to "or" and insert after paragraph (1) the following new paragraph:

"(2) is an officer, director, agent, or managing employee of such a provider, institution, organization, or agency, and"

Page 31, line 23: change "(2)" to "(3)".

Page 32, following line 3: insert the following new paragraph:

"(4)" An "agent" or "managing employee" shall include any person who exercises operational or managerial control over a provider, institution, organization, or agency, that is, one who, directly or indirectly, conducts the day-to-day operations including but not limited to such functions as "general manager", "business manager", "administrator", "director" (administrative or medical).

Page 32, line 17; page 33, line 7; and page 34, line 2: Delete "in" substituting therefor", or any officer, director, agent or managing employee in, or of".

These changes would extend the disabilities of a conviction to officers, directors, agents and managing employees of providers, institutions, organizations and agencies dealing in Medicare and Medicaid. This would prevent a person convicted of a criminal offense involving Medicaid or Medicare programs from being able to disguise his ownership or control interest, insofar as it is based on a percentage of the business, or to exercise control as an officer, director, agent or managing employee and would facilitate the total exclusion of anyone convicted of a crime against the Medicare-Medicaid industry from further participation in it.

Name	Criminal docket No.	Convictions	Sentence
1. Leonard Briggs, D.C.	75 Cr. 1025	False claims (sec. 287, title 18, U.S.C.)	6 mo confinement; 18 mo probation.
2. Peter J. Carnes, D.C.	75 Cr. 1026	do	3 mo confinement; 21 mo probation.
3. Raymond Jawer, D.P.M.	75 Cr. 1027	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	Do.
4. Sidney Gerber, D.C.	75 Cr. 1080	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	3 mo confinement; 1 yr probation.
5. Ira Feinberg, D.C.	75 Cr. 1081	False claims (sec. 287, title 18, U.S.C.)	2 yr probation; $1,000 fine.
6. Elliot Martin, D.P.M.	75 Cr. 1145	Fraud and false statements (sec. 1001, title 18, U.S.C.); filing false income tax return (sec. 7206, title 26, U.S.C.).	2 mo confinement.
7. Stanley Reichler, Clinic Administrator.	75 Cr. 1146	False claims (sec. 287, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	1 yr confinement; 2 yr probation.
8. Martin Levine, M.D.	75 Cr. 1147	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	3 mo confinement.
9. Joseph Raguseo, D.C.	75 Cr. 1148	Mail fraud (sec. 1341, title 18, U.S.C.)	1 mo confinement; 23 mo probation.
10. Ralph Sheldon Bell, M.D.	75 Cr. 1192	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18 U.S.C.).	3 yr probation; $5,000 fine; 1 yr service with Vista.
11. Sheila Toby Styles, Secretary.	75 Cr. 1201	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.); failure to file an income tax return (sec. 7203, title 26, U.S.C.).	2 yr probation; $500 fine.
12. Joseph Howard Ingber, D.C.	75 Cr. 1221	False claims (sec. 287, title 18, U.S.C.—2 counts); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, USC—2 counts); mail fraud (sec. 1341, title 18, U.S.C.).	5 yr confinement.
13. Sheldon Max Styles, D.C.	75 Cr. 1222	False claims (sec. 287, title 18, U.S.C.—2 counts); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, U.S.C.—2 counts); mail fraud (sec. 1341, title 18, U.S.C.); filing a false income tax return (sec. 7201, title 26, U.S.C.).	Do.
14. Tyler Ira Freedman, M.D.	75 Cr. 1236	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	1 mo confinement; 2 yr probation.
15. Donald Trager, D.C.	75 Cr. 1237	do	1 mo confinement; 35 mo probation; $10,000 fine.
16. Marvin Mosner, D.C.	75 Cr. 1251	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	3 yr probation.
17. Edwin Kimmel, D.C.	75 Cr. 1258	do	2 mo confinement; 22 mo probation.
18. Arthur Krieger, D.C.	76 Cr. 57	do	3 mo confinement; 2 yr probation.
19. Rene Clark (secretary)	76 Cr. 74	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	18 mo probation.
20. Morty Kazdin, D.C.	76 Cr. 98	do	1 mo confinement; 23 mo probation.
21. Arthur Paul Solomon, M.D.	76 Cr. 115	False claims (sec. 287, title 18, U.S.C.)	2 mo confinement.
22. David Friedman, D.C.	76 Cr. 155	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	1 yr probation.
23. John Errol Asher, Md	76 Cr. 518	False claims (sec. 371, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, U.S.C.).	1 yr confinement; 18 mo probation.
24. Robert March, D.C.	76 Cr. 114	False statements (sec. 1001, title 18, U.S.C.—10 counts); mail fraud (sec. 1341, title 18, U.S.C.—3 counts).	3 mo confinement; 2 yr probation.
25. Max Kavaler, D.C.	76 Cr. 110	False claims (sec. 287, title 18, U.S.C.—13 counts); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	4 yr confinement.
26. Theodore Ginsberg	76 Cr. 113	False statements (Sec. 1001, title 18, U.S.C.)	Not sentenced as yet.
27. Mark Buthorn	S76 Cr. 600	False statements (sec. 1001, title 18, U.S.C.—22 counts).	Do.
28. Gerald Corsover	76 Cr. 1125	Filing false income tax return (sec. 7206, title 26, U.S.C.).	1 yr probation, $5,000 fine.
29. Manlio Severino	76 Cr. 534	Conspiracy (sec. 371, title 18, U.S.C.); False claims (sec. 287, title 18 U.S.C.).	5 mo confinement $2,500 fine.
30. Clara Nemes	do	Conspiracy (sec. 371, title 18, U.S.C.)	2 mo confinement.
31. Seymour Feldman	76 Cr. 44	False claims (sec. 287, title 18) (43 counts); mail fraud (sec. 1341, title 18) U.S.C.—10 counts.	4 mo confinement.

Mr. ROGERS. Chairman Rostenkowski?

Mr. ROSTENKOWSKI. Thank you, Mr. Chairman.

First, I would like to thank you for your cooperation with respect to my correspondence with you. On Thursday of last week, Sam Skinner, our U.S. attorney in Illinois, advocated an up-front disclosure of ownership as a condition of participation or certification in medicare and medicaid. Would you also prefer such a required disclosure instead of the disclosure upon request which is presently in the legislation?

Mr. FISKE. I think this is a good suggestion. I think both George and I would suggest that.

Mr. ROSTENKOWSKI. Would it be helpful in detecting abuse if we could cross-reference ownership, where an individual owned, for example, both a nursing home and pharmacy participating in medicaid?

Mr. FISKE. Yes.

Mr. ROSTENKOWSKI. I am sure that you are well aware of what has been happening with these operators. Even after having been found guilty in one State, the opportunity remains for them to open up in another. We thought, in preparing Section 8 of the legislation, it would be wise for us to know what their past program record had been.

I am also happy that you agree that maybe section 3 disclosure should be a condition precedent to ownership. Thank you very much. You have been most helpful in coming here this morning to participate in this dialog with us.

Mr. ROGERS. May I just inquire as to your feelings about a statement made by the U.S. attorney from Illinois who suggested the upgrading of penalty but also that we leave in the misdemeanor section so it could be used in those cases where it may be needed. Do you think that is—of course, I realize a judge can put whatever is necessary up to those limits.

Mr. FISKE. My understanding of the proposal of H.R. 3 is to upgrade the penalties from a misdemeanor to a felony. Not that they are adding any new substantive violations. I think our position would be that we would like to see the penalties upgraded to felonies. I think that is particularly true with the portions of the two sections that are being amended that deal with kickbacks. The parts dealing with false statements could probably be prosecuted as felonies already under section 1001 of title XVIII. The other part of those two sections dealing with kickbacks which are presently misdemeanors we think would be more effective if they are made felonies, not only because it would provide a much better sentencing alternative for the judge, but I think in terms of getting U.S. attorneys around the country interested in prosecuting medicaid fraud, I think that more of them would be willing to devote more of their resources to this kind of prosecution if they saw felony convictions at the end of the line rather than misdemeanors. The evidence available to us would indicate that the kickback type of violation is probably one of the most, if not the most, prevalent and would be one of the easiest to prosecute if people spent the time at it.

Mr. Rogers. Well, now, I think the rationale given is that—to have some provision for plea bargaining, maybe to get them to turn evidence. I do not think it would be more so if it were a higher penalty, would it?

Mr. Fiske. No. There are other ways to accomplish that approach.

Mr. Rogers. We had heard that some of the offices of the U.S. attorneys did not put a high priority on this. Now we are going to have the Attorney General this afternoon. If he were to ask you from experience what would be some suggestions that you would give him as he starts to administer this program, to try to put greater emphasis on doing something about white collar crimes in the health industry, what would you particularly tell him?

Mr. Fiske. Well, one of the things I would urge him to do would be to right away get together a group of U.S. attorneys in the cities where medicaid fraud is the most rampant and have them addressed by people like Sam Skinner in Chicago, people from his office, and myself, and George.

Other U.S. attorneys that have spent a lot of time on medicaid fraud, because I think George, who has spent the better part of the last year and a half full time on this in our office would be the first to tell you that he has learned an awful lot in the year and a half; and a lot of it came very slow in the first 6 to 9 months.

He would be very happy to pass that experience on to anybody else that is really just getting started. I think we could save a lot of people a lot of time; and I would urge that people like Sam Skinner, who is an outstanding U.S. attorney, also have the opportunity to participate in that.

Beyond that, the other suggestion that I would make to the Attorney General is in terms of interesting U.S. attorneys in this kind of prosecution is being sure that they have the proper investigative help.

One of the biggest problems every U.S. attorney has is allocating his own resources in terms of the assistance available to him in terms of setting priorities in law enforcement in his own country.

There are always a tremendous number of competing demands that every community for specialized type of law enforcement. What the U.S. attorney would like is to have as much assistance as possible from investigators so that people like George do not have to do a lot of basic work that ought to be done by people who are trained investigators leaving the assistants with more time to prosecute the cases.

Mr. Rogers. Mr. Wilson, maybe you could tell us, have you had any prosecution convictions for abuse rather than outright fraud?

Mr. Wilson. Sir, are you speaking of abuse by recipients or abuse by providers?

Mr. Rogers. Well, either.

Mr. Wilson. Well, there is a fine line between abuse and fraud. We take a rather wide view. Really, it is a matter of semantics. If a person, if a doctor cheats, it is fraud. Other people may call it abuse. I think it is a matter of degree. I think the common definition of a fraud, if there is evidence of an intent, then it is fraud.

If there is just evidence of taking advantage of the system within the parameters of the system to the point where it becomes abusive and is obviously abusive, then it is abuse.

I would think even taking advantage of the system past a certain point is fraud and should be prosecuted as such.

Mr. FISKE. Mr Rogers, I could supplement that by saying that in these cases that have been described in our statement, we had a number of situations where doctors were operating in medicaid mills engaging in the practice which is commonly know—come to be known as pickpocketing, where a person would come into the mill complaining of a sore toe; and by the time the person got out of there, they had everything from a cardiogram to a chest X-ray, all of which was eventually paid for under the medicaid program.

We decided in our discretion not to make criminal prosecutions out of those situations, although you might well think—and I might well think—that those constitute an abuse of the system, because of the fact we felt it would complicate the prosecutions because there would be a lot of conflicting testimony about the need for a thorough preventive-type examination.

We really limited our prosecutions to cases where doctors submitted invoices for services that they did not perform at all, which is, of course, the classic fraud.

Mr. ROGERS. Thank you very much. My time is up, I have been advised by the staff.

Mr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I found your testimony very interesting and extremely helpful. Do you feel that those Federal agents who review shared health facilities for fraud and abuse, should have a few months training prior to then?

Mr. FISKE. I do. I think George can speak to that more specifically.

Mr. CARTER. Yes, sir.

Mr. WILSON. As we state in the statement, it is—the best background is either auditing or paramedical experience. As an example, the investigators we have working for us are out of the SRS Division of HEW; and they had experience with the program. They understand the program. They have taught themselves really the paramedical subjects. It is essential that an investigator have one of three qualities: either understand the program very thoroughly; have a good background of auditing, going in the books and tracing money when you are dealing with institutional providers; and the paramedical. If you have a group of investigators each having one of those skills, they can work together as a team and work very effectively. I think in addition to that, that their formal criminal investigative training should extend, at the very least, to enough of the law of evidence so they understand the elements of the crime they are investigating, so they can recognize what evidence is good in court and what evidence is insufficient; and also, they should know how to interview witnesses and take a statement in such a way that it will be done in the best manner for latter use.

Mr. CARTER. Including accountants and medical technologists in the group is an excellent idea, which I believe you mentioned.

Also you proposed that the Federal presence should be signified on the papers the doctor fills out and the patient should be required to sign them. I think that suggestion is excellent. In the State of New York, do you return a copy of the payments which have been made by medicaid to the patient?

Mr. WILSON. They do not, sir.

Mr. CARTER. That is the procedure which is followed by medicare in some States.

Mr. WILSON. In medicare they do; medicaid, they do not. As a matter of fact, in laboratories the method for ordering a test is for the doctor at the medicaid clinic to fill out an invoice, one part of an invoice, ordering certain laboratory tests and send that invoice which is a test request, in the form it is filled out, to the laboratory along with a specimen. The laboratory performs the test, sends the slip back to the physician ordering the test, completes the invoice, and sends it on to the city. Never the doctor or the patient ever see that original invoice on which the doctor orders the test. It is a simple matter for someone in a laboratory who wants to cheat a little bit to add on several more tests and add $10, $15 on every invoice.

Neither the referring physician nor the patient ever knows it. There is no cross-checking at all by the city between the invoices submitted by the laboratories and the invoices submitted by the doctors.

Mr. CARTER. Don't you think it would be wise to send the invoice back to both the physician who first ordered the test as well as to the patient? Or would it be too expensive?

Mr. WILSON. I am not so sure how much effect it would have sending it back to the patient, since unlike a medicare patient who must pay 20 percent, has a little more personal interest in the amount of the bill, a medicaid patient pays nothing. It would be just a piece of paper. I do think, however, there should be some feedback to the referring physician.

Mr. CARTER. Yes, sir. I have patients as it happens in medicare cases who show me these reports returned to them in which they stated, "I didn't see this doctor at these times." I think the patient in some cases should get this back, or in all cases, really.

Mr. WILSON. It would be a plus.

Mr. CARTER. Your testimony has been very helpful.

Mr. ROGERS. Mr. Duncan.

Mr. DUNCAN. Is it not true that most of the dramatic cases of medicare-medicaid fraud have occurred in our large major cities?

Mr. FISKE. It is true in our district which covers 11 counties, both urban and rural. Virtually every one of our medicaid prosecutions has been from the Borough of Manhattan.

Mr. DUNCAN. Not in your rural counties?

Mr. FISKE. That is right. We are not saying it does not go on there. Maybe it is a little harder to find. I think the volume——

Mr. DUNCAN. You are not recommending the additional staffing for every district attorney's office in the country?

Mr. FISKE. No.

Mr. DUNCAN. What do you recommend?

Mr. FISKE. We think that it should start at least in the major metropolitan centers.

Mr. DUNCAN. Do you not think that we might in an effort to correct the situation in the major cities, that we might give a little overkill in putting undue burdens upon the small providers?

Mr. FISKE. I do not personally think that is a problem, no.

Mr. DUNCAN. You think that the small providers in the rural communities can provide in these cases the same reports and the same restrictions as you would in the major cities?

Mr. FISKE. Well, the suggestions that we made are really in terms of what should go on these forms. That is really very minor. It simply requires the patient to sign it. I do not think that should be much of a burden for anybody.

Mr. DUNCAN. I think that is all.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Martin?

Mr. MARTIN. No questions, Mr. Chairman.

Mr. ROGERS. Mr. Rostenkowski?

Mr. ROSTENKOWSKI. When an individual is convicted of fraud, you mentioned you often ask for return of funds through a parallel civil prosecution under the Federal False Claims Act. I am interested, do these individuals usually pay Federal tax on the money that they permanently borrowed from the Government?

Mr. FISKE. Well, up to now, we have underway right now, as I mentioned earlier, a number of investigations with the Internal Revenue Service where we expect to show that a lot of them do not.

Mr. ROSTENKOWSKI. In other words——

Mr. FISKE. One of the most common things is paying kickbacks and then falsely deducting the kickbacks disguised as business expenses. That has been one area in which we have made tax cases already.

Mr. ROSTENKOWSKI. Thank you, Mr. Chairman.

Mr. ROGERS. Perhaps you are aware of what has happened in California in the involvement of organized crime in the health field. There was a story in the Post this morning about it. Have you found this to be true in New York?

Mr. FISKE. I would have to say that up until now, we do not have any specific hard evidence that we could recite to the committee to show that organized crime is involved; but I guess I would not ever discount it.

Mr. ROGERS. Thank you very much. Your testimony has been very helpful.

Mr. Corman, do you have any questions?

Mr. CORMAN. No questions, Mr. Chairman.

Mr. ROGERS. We are pleased to have you with us.

Thank you for your presence. It was most helpful. We are grateful to you for the job you are doing and for the testimony you gave the committee.

The next witness will be one of our distinguished colleagues who has taken—excuse me.

Mr. FISKE. I wanted to thank you for the home remedy.

Mr. ROGERS. Remember that whenever you start choking.

Our distinguished colleague from California, the Honorable John Moss has taken a vital interest in this matter. His subcommittee does oversight in this area and he has helped us in many areas and I am sure will continue to. Welcome to the committee.

STATEMENT OF HON. JOHN E. MOSS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Moss. Thank you, Mr. Chairman. I should say Mr. Chairmen. It is pleasant to be here. I may call on you very shortly for some medical advice. I have some impairment of speech at the moment, too. [Laughter.]

I understood that the chairman had prescribed earlier in the hearing a remedy. I was interested in his progress in this field.

Gentlemen, I do want to commend you for the introduction of H.R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments. The legislation will significantly strengthen the Government's ability to detect and take enforcement action against fraudulent and abusive activities by program providers, suppliers, and practitioners.

Such legislation is essential. As Chairman of the Subcommittee on Oversight and Investigations of the Interstate and Foreign Commerce Committee, I can report to you firsthand on the need for such legislation. We have found that an excessive and costly form of abuse in the medicaid program is the overutilization of various services.

For example, the subcommittee found in its examination of unnecessary surgery that an estimated $1 billion—$816 million under the medicare program and $272 million under the medicaid program—was spent in 1975 on unnecessary hospital procedures.

In human terms, this meant unneeded hysterectomies, tonsilectomies, and appendectomies, often with tragic consequences. For both fiscal and humanitarian reasons, unnecessary surgeries should be identified and stopped.

Unfortunately, the medicaid program was not even able to report the amount of surgery that it paid for.

Similarly in other critical points in our health care delivery system—medicaid mills, nursing homes, and prepaid health plans—the subcommittee discovered a paucity of essential information. Based on these investigations, it is my conviction that a uniform system of cost accounting is an essential condition precedent to reform of many medicaid and medicare abuses. Without standardized accounting and reporting, we cannot insure that our limited health care dollars are indeed going for patient care.

Uniform reporting alone will not do. Standard statistical units and uniform accounting practices must undergrid any such reporting systems. For example, a requirement that an institution report on the costs of radiological services is meaningless if one institution measures cost by patient visit while another relates costs to each exposure to radiation.

In addition, these two institutions could very well allocate administrative and support services in the radiological cost center in very different ways. In summary, uniform standards are essential to the development of meaningful, comparable data.

Not only is a uniform system necesary for effective control of abuse, it will lead in many instances to a generally more efficient health care delivery system. The Washington State Cost Commission has described a case where the comptroller of a hospital which spent $35,000 to change over to a required uniform chart of accounts reported that the new system resulted in cost savings of $350,000, a savings which arose from changes that were made possible by identifying internal inefficiencies. The improved management data which resulted alone justified the relatively small one-time cost to switch to the mandated uniform cost accounting system.

In order to address these problems, Chairman Rogers and I recently introduced H.R. 4211. This measure brings to this committee the policy of requiring uniform accounting and reporting in the medicare and medicaid programs.

This is accomplished by building on the work already being done by HEW pursuant to the National Health Planning and Resources Development Act. Specifically, the uniform accounting system proposed in this amendment would include six major components:

One: Uniform accounting practices;

Two: A uniform functional chart of accounts:

Three: Uniform statistical measures of productivity;

Four: Uniform methods and statistical measures for cost accounting and cost allocation among accounts;

Five: A uniform cost and statistical reporting system; and

Six: A uniform discharge abstract and uniform billing system.

Once developed, this system will be the basis for determining costs under medicaid and medicare and the reporting of data necessary to the effective administration of these two programs.

The bill provides that in the establishment of the system, there will be opportunity for public participation in accordance with the Administrative Procedure Act. Specifically called for in the bill is cooperation between the Secretary and organizations representing providers of health services, the Financial Accounting Standards Board, the General Accounting Office, the National Center for Health Statistics, and the National Council on Health Planning and Development.

In closing this short statement, I commend this approch to you. I would be pleased to answer your questions.

I want to commend you and Chairman Rostenkowski for the joint cooperation evident in this joint hearing.

Mr. Rogers. Thank you very much.

Chairman Rostenkowski?

Mr. Rostenkowski. Thank you, Mr. Chairman. I certainly appreciate the great contribution that my colleague John Moss has made. Mr. Chairman, I just wondered, would this legislation not best be incorporated in what the administration is going to propose to the Congress, I should imagine by the latter part of April, on hospital cost controls?

Mr. Moss. I think it could be there, or it could be incorporated in the legislation now being considered by the two committees. I think it is highly relevant to either, although it certainly fits squarely into the context of controlling or eliminating abuses and inefficiency in the health care delivery system.

Mr. Rostenkowski. Well, I certainly agree with the principle of the legislation. I just felt that with the legislation that the administration is going to propose, that it would best fit into that category.

Thank you, Mr. Ross.

Thank you, Mr. Chairman.

Mr. Rogers. Thank you.

Mr. Carter?

Mr. Carter. Thank you, Mr. Chairman.

I want to compliment my colleague for presenting an excellent statement. How long do you estimate it would take to phase in such a uniform cost accounting system?

Mr. Moss. It would undoubtedly take several years. I recall when we rewrote the Securities and Exchange Commission Act we mandated that the Commission, in cooperation with the Federal Accounting Standards Board, develop uniform accounting standards for the securities industry. We are moving along nicely on that product. A comparable project deals with the uniform system of accounting in the petroleum industry that was mandated by title V of the act this committee reported in 1975.

Mr. Carter. How much do you estimate it would cost?

Mr. Moss. It is rather difficult at this point to give an estimate of cost; but to convert, and you can do that over a phased system, should not be a heavy burden even on small hospitals

Mr. Carter. On the other hand, how much would it save?

Mr. Moss. I think that the ratio of saving, if the one case in Washington is an indication, the saving could be substantial. In that case, the ratio was approximately 10-to-1 saving over cost.

Mr. Carter. Would the States contribute part toward the cost of this uniform accounting system or would it be completely federally funded?

Mr. Moss. I think that the States would in some instances be cooperating. Certainly the kind of situation that you are familiar with in my State, the most notorious of the four or five participants in the prepaid health plans did fail in doing an effective job of reporting and accounts. The Omni-Rx situation would probably not have occured had a uniform system of accounting been in effect.

Mr. Carter. I thank the distinguished gentleman.

Mr. Rogers. Mr. Duncan?

Mr. Duncan. Thank you, Mr. Chairman.

I also want to welcome our colleague to the subcommittee hearings. What do you mean by phasing in? You mentioned that this program of uniform cost accounting could be phased in. Just what do you mean?

Mr. Moss. I believe that any accounting system when you change from one to another, you normally institute the change by steps in order to phase it in. You do not just suddenly go to a completely new accounting system.

Mr. Duncan. Do you think you should have the same type of accounting system for a small rural hospital that you would have for a large metropolitan hospital?

Mr. Moss. I think the essential elements of the accounting system could be the same. Obviously, there would be a scope or a need much greater in the larger hospitals than in the small. The essential elements in accounting systems which would permit uniform reporting and uniform interpretation I think could be placed into effect at a minimal cost.

Mr. DUNCAN. Some of these providers who are really giving good service are honest and following every regulation are now overburdened with reporting, and to add an additional burden upon them because of the default indications of a few large providers in the major metropolitan centers does not make sense to me.

I have heard the costs could run up to as high as $50,000 for a conversion to the uniform accounting system.

Mr. MOSS. We do have some figures we can supply additional ones from the State of Washington that would indicate that a $50,000 conversion figure would be a way-out figure for a small hospital.

Mr. DUNCAN. If you do that nationwide, you are running into a lot of money, are you not?

Mr. MOSS. If in fact that was the case, it would run into a considerable amount of money. That would have to be balanced against the offsetting savings. But, I think rather than burdening the small hospitals, the uniform system once put into effect would minimize the amount of work. I think frequently that there are unnecessary reports requested that are in a sense duplicative because we do not have uniform accounts underlying uniform reporting.

Mr. DUNCAN. Do you think it might be a good idea to perhaps exempt smaller-type hospitals?

Mr. MOSS. We would be happy to look at this further as we go along with some inquiries now underway in the investigating subcommittee. My first reaction is that it would be to their disadvantage if they were exempted. I think they have much to gain by having improved accounting procedures.

Mr. DUNCAN. I agree that something must be done. Also, I think that our big problem would be that we are actually punishing the good people, the good providers, for something that a few did wrong. It would create a burden on them.

I would personally like to see perhaps an exemption of certain categories, or a different system.

Mr. MOSS. I would sincerely hope that no institution would regard the adoption of the uniform system as being in any sense punitive. I think as we go to an increasing demand on the services of the health care providers, and an ever more significant role of Government in the delivery of those services that simplification of the entire burden of accounting and reporting is going to have to be based on arriving at some more uniform method or we will inevitably have a pattern of repeated inquires for information which, if more readly available under uniform guidelines, could have been provided at the first. I think many times the return for more and more information is because the request could not be produced from the records available the data required.

Mr. DUNCAN. The people at the small hospitals I have talked to, they do not think you are doing them any favor by pursuing this legislation—and it is a burden when you require them to employ a CPA or a full-time accountant, which is just about what it would do under this legislation.

I want to do something, but I also do not want to put an undue burden upon people who do not need it and do not want it and have more now than they can do with in the reporting system. I do want to commend you, though, for—I have enjoyed the colloquy with you. My time is up.

Thank you very much.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Martin?

Mr. MARTIN. Mr. Chairman, Mr. Moss, I appreciate your being here to discuss this idea. I gather it would be your opinion that there would not be any legitimate providers who would cease to provide care under the Medicaid or Medicare Act if this requirement were imposed upon them?

Mr. MOSS. That would be my opinion, yes.

Mr. MARTIN. So you do not see it as a particular burden?

Mr. MOSS. No.

Mr. MARTIN. A burdensome problem for them?

Mr. MOSS. No.

Mr. MARTIN. You do not foresee it would be necessary for us to pay for the costs of an accounting system?

Mr. MOSS. I am not certain looking over some of the patterns of payment that we are not in the final analysis paying for most of the costs in any event.

Mr. MARTIN. Does that mean you would or would not?

Mr. MOSS. I am saying—you are asking a direct question: Do I envision this as being a cost that we would pay directly. I do not necessarily envision it in that manner. But the ultimate cost could to a large extent, be to the Federal system, yes.

Mr. MARTIN. Since, of course, that standard, that particular connection would apply to a lot of assorted business areas in the country where the Government has some relationship or subsidy or support. Would it be your general feeling that we need to do this in all walks of life, anyone who is engaged in interstate commerce, handles a dollar of money, that we should set standards?

Mr. MOSS. Indeed not. I think only where the reporting is a very essential part in the administration of a program should we attempt to simplify the task of reporting. I might add that when we modified the Securities and Exchange Act to require the uniform standards of accounting, that it was done without any significant opposition from within the industry.

Mr. MARTIN. Within the Securities and Exchange industry?

Mr. MOSS. That is correct, because the reporting that they file with the Commission is a very essential element in the regulation of the industry. Increasingly that is going to be true in the delivery of health care; and to have a variety of reporting systems to payors of the cost—Blue Cross, Blue Shield, other programs does not relieve anyone of burdens. Sometimes it tends to hide them. I think a review of some of the accounting procedures could prove highly beneficial in bringing about economies in operation.

Mr. MARTIN. That is an interesting comparison with the securities industry. You say that there's no opposition in that industry?

Mr. Moss. I said no significant opposition. I have never known anything that could be raised without opposition. Significant opposition was not there.

Mr. Martin. Certainly there was no significant opposition in that case. Is there any significant opposition, in your opinion, to this proposal?

Mr. Moss. Well, it's surfaced recently. There have been——

Mr. Martin. Opposition?

Mr. Moss. There have been concerns expressed within the last two months. On the other hand, there is an increasing body of support that is forming; and it is coming forward to indicate interest in securing enactment of legislation of this type.

Mr. Martin. The support is certainly significant. Is any of the opposition significant in your opinion? What I am trying to get at——

Mr. Moss. At this moment, again, we haven't the firm support nor the firm opposition. The indicated opposition in some instances could be significant. I hope in further conversations with some of the representatives to convince them that they are not going to be given an onerous task because of the legislation.

Mr. Martin. My time has lapsed, Mr. Chairman.

Mr. Rogers. May I say this? I think the American Hospital Association has even recommended that there be a uniform system to its own members to bring about better management and to save money. I believe your own State of California has instituted a system at the behest of the State where there has been cost savings effected. Would the gentleman comment on that?

Mr. Moss. That is correct. We get into trouble when we find that we haven't adequate accounting standards. It is increasingly important that we have the best possible accounting standards.

Mr. Rogers. I agree with that.

Thank you for your helpful testimony and for the work your subcommittee has been doing in this field. Thank you so much.

Mr. Moss. Thank you, Mr. Chairman.

Mr. Rogers. The next witness will be the American Hospital Association, Leo J. Gehrig, the senior vice president; and Allen J. Manzano, vice president. Welcome. Your statement will be made a part of the record.

You may proceed.

STATEMENT OF LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, AND ALLEN J. MANZANO, VICE PRESIDENT

Dr. Gehrig. Good morning, Mr. Chairman. I am Leo J. Gehrig, M.D., senior vice president of the American Hospital Association, and with me is Allen J. Manzano, a vice president of the association.

Our association represents more than 6,500 member institutions, including most of the hospitals in the country, extended and long-term care institutions, mental health facilities, hospital schools of nursing and over 24,000 personal members. We have a longer statement we would like to submit for the record and I will abstract from that statement.

Mr. ROGERS. Without objection, so ordered.

Dr. GEHRIG. Congressman Rogers, when I looked up this morning I thought I was sick. I thought I had double vision. I must compliment you two for holding this joint hearing. I ask for no prescription at this point.

Mr. ROGERS. We hope you have 20–20 vision and that it continues.

Dr. GEHRIG. In addition to talking to H.R. 3, we would also like to comment on H.R. 4211.

First let me say that we appreciate the opportunity to present testimony at this joint hearing on H.R. 3, the medicare-medicaid antifraud and abuse amendments.

We fully support the purpose of H.R. 3 which is to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs. Statements have been made by a number of the sponsors of this legislation to the effect that they feel the vast majority of health care providers and institutions are doing an honest professional job in seeking to provide medically necessary care of high quality to beneficiaries of Government health care programs. We are confident that this is so. The fraud and abuse that does, however, exist in the medicare and medicaid programs damages the reputation of honest providers, undermines public support for the programs, and defrauds both beneficiaries and taxpayers. More effective measures to detect and curb fraud and abuse in the medicare and medicaid programs are thus desirable and the American Hospital Association last year officially endorsed that goal. The resolution approved by the AHA House of Delegates on this matter is as follows:

> Whereas, the total funds available for health care programs are limited, and should be used only to meet the legitimate needs of those covered by the programs; and
>
> Whereas, the American Hospital Association and its member institutions have a vital interest on behalf of the public in helping to assure that no funds be spent for unneeded services or in fraudulent practices; therefore be it
>
> *Resolved,* That the House of Delegates of the American Hospital Association pledges its continued support for an cooperation with the Federal Government in a strengthened program to eliminate fraudulent practices in the Medicare and Medicaid programs, so that all funds that are appropriated for health care of the poor, elderly and disabled achieve their maximum potential.

We have attached to our statement a series of recommendations we believe would improve the bill. The first I would touch briefly on. We recognize fully the problem of describing a medicaid mill. The word "share health facility" has been used. Your staff has been assistive to us about a concern that we have. The American Hospital Association and its member institutions have been concerned with hospital costs, have encouraged administrative actions to decrease costs wherever possible. One of these actions has been in the use of shared services and facilities.

We had expansion this last year of the 501(e) authority of the IRS code relating to hospital shared services. We are concerned that this positive and constructive action might be misconstrued because of terminology. We recognize the problem and would add one minor suggestion in connection with the bill to assist us in separating those two items.

Going on to the professional standards review organization activity, we do believe under section 5(h) of H.R. 3 that the request for a further data system goes beyond what is needed. The authority of the Secretary to evaluate existing systems we believe is adequate at the present time, and suggest that this not be included.

We do believe in the following pages there are several actions which you are taking that we strongly support. There are minor suggestions in connection with them for change.

We get to page 7, section 11. We understand the efforts of the committee to make medicaid the payor of last resort. I think the committee staff is particularly well informed here—that there are problems where there may be because of State law or other contracts a secondary coverage which prohibits payments for medicaid covered services. We are concerned that in dealing with this issue, you should be sensitive to the fact that the hospital may be left "holding the bag" or receiving very delayed payment for legitimate services to medicaid beneficiaries because of a confusion regarding another responsibility for payment through another source.

In addition there is one other broad aspect of the fraud and abuse bill that you may not wish to deal with in these hearings, but we would like to introduce the subject at this time.

I believe that if the committee's efforts are effective, fraudulent activities are going to be stopped in a number of areas. One has to look at this very carefully, understanding that through medicaid mills a large volume of services has been provided to people needing services. Now, there may have been fraudulent activity. The quality of such care may be inappropriate. We are not arguing for its continuation. I believe, however, the committee must visualize that in moving in this direction, it may well render a very, very important segment of our population in need of other resources for health care. Basically in the major urban areas the other resources have been, to date, major hospitals both public and private. I would point out to the committee now, and we would hope in subsequent medicaid-medicare reform this problem will be considered: These same facilities are under very, very difficult financial conditions, both because of eligibility of determination, eligibility limits, and limits of payment now existent in the medicaid program.

I introduce this matter here because I think in moving in one direction, while we fully support it and recognize its importance, we would hope the committee would also recognize that there may be other problems raised here which we need to address in the months ahead.

Finally, Mr. Chairman, because we have very serious concerns with regard to the bill that you and Mr. Moss introduced, I would like Mr. Manzano, who is technically much more qualified to address the issue, to discuss our position on H.R. 4211.

Mr. Rogers. Certainly.

Mr. Manzano. Thank you, Mr. Chairman. We understand that the primary subject of this joint committee hearing is legislation to improve the ability of Government to prevent, detect and punish fraud and abuse in the medicare and medicaid programs, but that you have decided also to give consideration to H.R. 4211. This bill, which was just introduced last week, would modify section 1533(d) of the Public Health Service Act and require the Secretary of Health, Education, and Welfare to develop and establish a uniform functional accounting system, which would be mandated for use by institutional providers of services under medicare and medicaid. It is our understanding that the original intent of section 1533(d) was development of accounting and statistical systems to improve reimbursement of health care institutions and was not related to the issue of fraud and abuse in Government health programs. If this latter issue is to be dealt within section 1533(d) of the PHS Act, the work that has been done toward implementation of the section should be carefully examined to determine whether it serves this additional objective.

In various ways, the orginal section 1533(d) may not serve the present purpose and intent of improving the Government's ability to curb fraud and abuse. For example, the current section 1533(d) provides for development of a uniform system of calculating rates to be charged health insurers of all kinds. The proposed amendments contained in H.R. 4211 suggest that the Secretary of Health, Education, and Welfare could change such reimbursement in any way he chooses, and then require all hospitals to enter into arrangements with Blue Cross and other private insurers, as well as with medicare and medicaid that adhere to the reimbursement approaches designed by the Secretary.

Mr. ROGERS. May I point out here that you misread the bill. I don't think there is any authority to have the Secretary back that up, either to change the reimbursement—I don't believe so. You may proceed.

Mr. MANZANO. Instead of attempting to respond to every provision in H.R. 4211 as introduced, I will discuss in broad terms uniform accounting practices and uniform productivity measures, discharge abstracts, and uniform billing.

If we have correctly identified the intent of H.R. 4211—accurate reimbursement and improved comparisons—it seems to us the logical way to proceed is to determine what accounting measures are required to advance these purposes. The data that will be used for these purposes will have to be incorporated in reports to those who approve rates or make payments.

Thus, the matter to be addressed is such reports. For these reports to be the basis for comparisons among institutions, the institutions that are to be compared must submit reports that are uniform.

But this does not mean that every hospital in the United States must submit its report on an identical form or basis, because meaningful comparisons cannot be made between a 10-bed rural hospital with simple services and a 1,000-bed medical center.

Similar institutions should, however, report similarly. Data suitable for uniform reporting should be collected for that purpose, and we do not argue against further appropriate accounting requirements that are needed to yield uniform reports.

However, establishment of uniform accounting requirements that go beyond the need is not good in itself. Where accounting requirements unrelated to a known objective are imposed, they are likely merely to increase accounting costs to no advantage. We urge that requirements of this sort be rejected as counterproductive to our efforts to reduce health care costs.

While the proposed language for amending title XVIII of the Social Security Act suggests use of the uniform accounting system that would be mandated for medicare and medicaid reimbursement for such other purposes as income tax reports, SEC reports, internal management reports, and corporate reporting to stockholders, a system developed for reimbursement is not likely to be suited to these other purposes.

Imposition of new requirements will thus be costly and involve the use of more than one accounting system by many hospitals.

A large Portland, Oreg., accounting firm recently undertook a study of the hospital costs that would be associated with conversion to a uniform functional accounting system such as this bill proposes.

Their study reports that costs of such conversion range from $5.000 to $50.000 for a single hospital, and that the typical cost would be $20,000. On a national basis, the total conversion cost would be $140 million, and this does not include the significant cost of maintaining a separate system for internal management control purposes.

There is very limited capacity and knowledge for measurement of the productivity of health care services, which the bill proposes be undertaken.

For example, there is limited capacity to measure the success of curing illness and there is virtually no measure for the degree to which the pain of those who cannot be cured is eased.

Although some measures of input and output exist for some hospital operations and cost centers, they are at best only indicators of productivity that often change as a result of changes in technology and medical practice.

Application of uniform measures of productivity, assuming their feasibility, would require the collection and reporting of difficult statistics which would be very costly, particularly to insure reliability and validity.

In addition, such an effort would duplicate and replace existing specialized methodologies and systems in many hospitals without any recognizable benefit to the hospital or to the community at large. Clearly, the cost of this proposal would far outweigh its potential benefits.

The bill also proposes establishment of a uniform discharge abstract. The American Hospital Association has long been on record as opposing a uniform abstract for collecting patient discharge data, yet we do support the establishment of an appropriate compilation of uniform discharge data and standard definitions.

The specification of a uniform discharge abstract form would unnecessarily require hospitals to incur costs in converting from existing systems designed for their use to new systems to meet the new requirements proposed in the bill.

In most cases, hospitals, using existing data systems, are capable of and already do collect the necessary data required by a multitude of Federal and State agencies.

Here, too, we must caution you concerning the considerable additional expense in system conversion and duplicate data preparation.

The American Hospital Association has long supported the concept of a national uniform billing system. Since 1968, we have worked with representatives of the Bureau of Health Insurance, Social and Rehabilitation Service, and other third-party-payer groups to get acceptance of one billing form that would save millions of health care dollars annually.

I must point out, however, that it has not been hospitals who have delayed the implementation of this uniform bill. Rather, the Government, with its everincreasing complexities in State and Federal regulations, has prevented its easy development and implementation. We support continued efforts to finally achieve this goal.

The remaining problem hindering the necessary cooperation of all payers is found in medicaid. If legislation can resolve this issue, we would be most happy to cooperate in its development.

In view of the above, we are opposed to H.R. 4211 in its present form. You may be sure, however, that we stand ready to assist in any way we can to modify the bill to facilitate its purposes of improving the accuracy of reimbursement determinations and improving our ability to compare like institutions that provide like services.

We will be pleased to respond to any questions from the committees.

Mr. ROGERS. Thank you very much.

[The prepared statement follows:]

STATEMENT OF LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Leo J. Gehrig, M.D., Senior Vice President of the American Hospital Association, and with me is Allen J. Manzano, a Vice President of the Association. Our Association represents more than 6,500 member institutions, including most of the hospitals in the country, extended and long-term care institutions, mental health facilities, hospital schools of nursing and over 24,000 personal members. We appreciate the opportunity to present testimony at this joint hearing on H.R.3, the "Medicare-Medicaid Anti-Fraud and Abuse Amendments," and in accordance with sugestions made in discussions with staff of your committees, we will testify also on H.R. 4211, a bill introduced just last week that would require the use of a single functional accounting and statistical system, and the making of uniform reports by institutional providers of services to Medicare and Medicaid beneficiaries. I shall present our testimony on HR. 3 and Mr. Manzano will then testify regarding H.R. 4211.

First, let me say that we fully support the purpose of H.R. 3, which is to strengthen the capability of the government to detect, prosecute and punish fraudulent activities under the Medicare and Medicaid programs. Statements have been made by a number of the sponsors of this legislation to the effect that they feel the vast majority of health care providers and institutions are doing an honest professional job in seeking to provide medically necessary care of high quality to beneficiaries of government health care programs. We are confident that this is so. The fraud and abuse that does, however, exist in the Medicare and Medicaid programs damages the reputation of honest providers, undermines public support for the programs, and defrauds both beneficiaries and taxpayers. More effective measures to detect and curb fraud and abuse in the Medicare and Medicaid programs are thus desirable and the American Hospital Association last year officially endorsed that goal. The resolution approved by the AHA House of Delegates on this matter is as follows:

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We have studied the provisions of H.R. 3 and wish to share with you some concerns regarding certain provisions of the bill. We will also offer some recommendations for changes in the bill as introduced.

Section 3(b) of the bill defines for purposes of the Social Security Act the term "shared health facility" to which certain reporting and penalty requirements would be applicable. The summary of the bill carried in the Congresonal Record refers to such facilites as "so-called Medicad mills." We appreciate the difficulties involved in trying to define "Medicaid mills" and it is unfortunate that the term "shared health facility" is used in this context.

As you know, Congress has enacted laws to foster shared services and cooperative activities in the health field to promote efficiency and cost savings. Among such laws are Section 501(e) of the Internal Revenue Code regarding tax-exempt cooperative hospital service organizations and P.L. 93–641, the National Health Planning and Resources Development Act, which establishes as a priority national health goal "the development of multi-institutional arrangements for the sharing of support services necessary to all health institutions." Since use of the term "shared health facility" for "Medicaid mills" may well cast unfavorable connotations on desirable cooperative arrangements in the health field, such as the cited laws seek to encourage, we regret that some other name has not been used.

We have noted the proviso in the definition which excludes from the term "shared health facility" providers of services as defined in Section 1861(u) of the Social Security Act (this includes hospitals, skilled nursing facilities and home health agencies); health maintenance organizations as defined in Section 1871 of the Social Security Act; cooperative hospital shared services organizations meeting the requirements of Section 501(e) of the Internal Revenue Code; and public entities. As a further clarification, we recommend that the proviso be amended to specifically exclude other arrangements whereby a group of hospitals acting together provide services to the members of the group.

Recommendation.—That the definition of "shared health facility" in the proposed new Section 1125 of the Social Security Act (Section 3(b) of H.R. 3) be amended by striking the last four words therefore, and substituting therefor, "other arrangements whereby a group of hospitals acting together provide services to the members of the group, or any public entity."

SECTION 5: AMENDMENTS RELATED TO PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Section 5 of the bill contains a number of amendments related to PSROs which we understand are intended to facilitate review by PSROs of services provided by "Medicaid mills." The section also contains other amendments pertaining to the PSRO program and to data collection activities for purposes of evaluating the impact of the program on health care services. I would like to comment on some of these.

Sec. 5(h).—We question the need for subsection (h) of Section 5, which would amend Section 1165 of the Social Security Act. Under this section the Secretary is already directed and authorized to provide for correlation and interchange of the volumnous amount of data and informaton that is collected by agencies and organizations having review, control or administrative functions under Medicaid. This existing authority to obtain and correlate currently available data appears to us to be adequate for evaluation of PSRO activities without requiring the Secretary to set up a costly new data collection system.

Sec. 5(d)(4).—This provision of the bill would completely rewrite Section 1155(g) of the Social Security Act. The current law mandates review of institutional services by PSROs and permits them to take on additional review responsibilities such as review of long-term and ambulatory care only if the PSRO requests such responsibility and the Secretary approves the request. The new Section 1155(g) proposed by Section 5(d)(4) of H.R. 3 deals only with the priority the Secretary is to accord requests by a PSRO for review responsibility with respect to services furnished in "shared health facilities," and makes no reference to PSRO requests with respect to review of other non-institutional health care services. Thus, a question may arise as to whether the Secretary would have authority under the proposed new Section 1155(g) to unilaterally require a PSRO to review such other health care services as ambulatory care in a non-institutional setting without a request from the PSRO. The Secretary may not do so under present law, and we think language should be added in the proposed new Section 1155(g) to make clear that it does not give the Secretary, in the absence of a request from the PSRO, authority to unilaterally require a PSRO to assume responsibility for review of ambulatory care and other health care services provided in non-institutional settings.

Sec. 5(b).—This section of H.R. 3 proposes amendments to Section 1154 of the Social Security Act, which deals with the conditional status of a PSRO during its trial period, that is at present limited to 24 months. We support the amendment that would authorize the Secretary to extend such trial periods for an additional 24 months. We understand that only some 15 or so PSROs are likely to qualify for operational status within the present 24-month period, which is not too surprising n view of the fact that acceptable methodologes have not been created for meeting some review responsibilities, such as long-term care, ambulatory services and ancillary services. Some PSROs that have been in operaton for 30 months are still not able to perform all required reviews. Allowing PSROs an additional 24 months of conditional status would afford time for additional work on development of methodologies, time for more adequate training of the professional personnel necessary for performance of review requirements, and allow further time for identification of appropriate factors for data collection. We feel the provision would be further strengthened and improved by including, in the amendment, authority for a PSRO to have operational status for certain review responsibilities and conditional or trial status for other review responsibilities. This would make possible a smoother implementation of each additional review requirement assigned to a PSRO.

Since no adequate definition exists for "ancillary services," which may include anything from food service to housekeeping and grounds keeping items, we feel the specification in Section 5(b) of the bill that review of services provided by or in hospitals shall include review of "ancillary services" is inappropriate at this time. Frankly, we don't believe that anyone knows how to conduct reviews of such items, and we know of no studes regarding the cost effectiveness of conducting such reviews. We would like to see the phrase "(including ancillary services)" removed from the revision of Section 1154(b) of the Social Security Act that is proposed in Sec. 5(b) of H.R. 3.

Sec. 5(a).—This Section of H.R. 3 would amend Section 1152(a) of the Social Security Act to provide that when a PSRO, whether conditionally designated or otherwise, performs review responsibilities in a competent manner, similar review and control activities will not be required, except as specified by the Secretary. We certainly agree that duplication of functions and review, certification and similar activities should be stopped when a PSRO is doing a satisfactory job, and we wholeheartedly support this amendment.

Sec. 5(c).—Section 5(c) of the bill would amend Section 1155(b)(3) of the Social Security Act to give PSROs authority to abstract pertinent records of providers of services in connection with their review activities. We have no objection to the abstracting of pertinent patient care records. I would like to point out, however, that the business of PSROs is the review of patient care and not review of the business practices of providers. There are many records of a health care institution or other provider, such as personnel records, that are not directly related to the PSRO review of health care services and ought not to be open to PSROs. Such matters are the corporate responsibility of an institution's board of trustees. PSROs should be able to examine and abstract only pertinent patient care records, and to clarify the point we recommend that Sec. 115(b)(3) of the Social Security Act be amended to read "examine and abstract pertinent patient care records of any practitioner or provider (etc.)."

Sec. 5(j).—We understand this section of H.R. 3 is designed to clarify the legislative authority for the Federal government to assume the full costs of defense of PSROs and any employees thereof in suits based on performance of the PSRO's duties and functions. It does, however, provide for the federal government to assume the costs of defending hospitals and their employees in suits based on the carrying out of review functions delegated to hospitals by a PSRO. We ask that you and your committees include such authority in Section 5(j).

SECTION 11: MEDICAID AS PAYOR OF LAST RESORT

Section 11 of H.R. 3 would add a new paragraph to Section 1902(a) of the Social Security Act, the purpose of which is to make Medicaid the payor of last resort. We understand the provision is primarily aimed at achieving savings for the Medicaid program by denying reimbursement under Medicaid for care or services which some other agency, organization or person would be obligated to provide but for an exclusion or exemption from such liability under a contract or a state law. Regardless of the merits of the idea, we question its relevance in a bill focused on the elimination of fraud and abuse in the Medicare and Medicaid programs.

Our concern with regard to Section 11 as drafted is twofold. It could operate to leave providers "holding the bag," that is, receiving no payment for services provided some Medicaid eligibles, and it could seriously delay Medicaid reimbursement payments due providers.

The section would prohibit payment by the Medicaid program for certain services provided Medicaid eligibles because the services provided are presumed to be covered under another program or medical insurance policy. Such presumption could be made despite the fact that a state law, such as a state workmen's compensation law, or a provision of a private medical insurance contact serves to exclude or exempt the non-Medicaid source from liability to pay for the services that have been provided. While Sec. 11 of H.R. 3 would effectively bar Medicaid payment for the services in such instances, it contains no assurances or requirement that payment will be made by another coverage or payment source. This could result in additions to the "bad debt" burden of a hospital or other provider that would eventually show up in higher bills for other patients.

A second concern regarding the provision arises from the fact that it does not address such issues as how a provider can determine in each individual case whether any agency, or other person may have an obligation to pay for the services being provided a Medicaid eligible. We fear payments due providers under Medicaid would be slowed down greatly and that the potential impact of such delay could be quite serious from a cash flow standpoint. We believe this provision needs further study.

Recommendation.—That Section 11 of H.R. 3 be deleted from the bill and accorded further study.

Finally, Mr. Chairmen, I wish to point to the simple fact that "Medicaid mills," despite the occurrence of fraudulent activities, provide a large volume of services which may be of questionable quality to poor people who have few alternative places to go for care. Such alternate sources of care are for the most part the outpatient departments of large inner city, public and voluntary nonprofit hospitals. These hospitals are already in serious financial straits and the nonresponsiveness of Medicaid with respect to patient eligibility and less than cost reimbursement for outpatient services are very significant factors. Poor patients who need health care are often not eligible for the Medicaid program, and the hospital winds up with a bad debt. Even when Medicaid eligibility is established, reimbursement payments for outpatient services are frequently below the hospital's costs. It should be recognized that the hoped-for closing of fraudulently operated Medicaid mills will increase the difficulties of those who are striving to serve the poor well and honestly. We believe, therefore, that your Committees should consider ways to make it easier and simpler for poor patients to apply for and establish Medicaid eligibility and ways to ensure that hospitals are paid the full cost of ambulatory care provided Medicaid beneficiaries. While this is a matter that may be more appropriate in connection with the Medicare and Medicaid Administrative and Reimbursement Reform legislation which we understand is to be considered at a later date, the seriousness of the problem impels me to bring it to your and your Committees' attention at this time.

Mr. Manzano will now present the Association's testimony on H.R. 4211.

Mr. **Manzano**. We understand, Mr. Chairman, that the primary subject of this joint committee hearing is legislation to improve the ability of government to prevent, detect and punish fraud and abuse in the Medicare and Medicaid programs, but that you have decided also to give consideration to H.R. 4211. This bill, which was just introduced last week, would modify Section 1533(d) of the Public Health Service Act and require the Secretary of Health, Education and Welfare to develop and establish a uniform functional accounting system which would be mandated for use by institutional providers of services under Medicare and Medicaid. It is our understanding that the original intent of Section 1533(d) was development of accounting and statistical systems to improve reimbursement of health care institutions and was not related to the issue of fraud and abuse in government health programs. If this latter issue is to be dealt with in Section 1533(d) of the PHS Act, the work that has been done toward implementation of the Section should be carefully examined to determine whether it serves this additional objective.

In various ways, the original Section 1533(d) may not serve the present purpose and intent of improving the government's ability to curb fraud and abuse. For example, the current Section 1533(d) provides for development of a uniform system of calculating rates to be charged health insurers of all kinds. The proposed amendments contained in H.R. 4211 suggest that the Secretary of Health, Education and Welfare could change such reimbursement in any way he chooses, and then require all hospitals to enter into arrangements with Blue Cross and other private insurers, as well as with Medicare and Medicaid, that adhere to the reimbursement approaches designed by the Secretary.

Instead of attempting to respond to every provision in H.R. 4211 as introduced, I will discuss in broad terms uniform accounting practices and unform productivity measures, discharge abstracts and billing.

UNIFORM ACCOUNTING PRACTICES

If we have correctly identified the intent of H.R. 4211—accurate reimbursement and improved comparisons—it seems to us the logical way to proceed is to determine what accounting measures are required to advance these purposes. The data that will be used for these purposes will have to be incorporated in reports to those who approve rates or make payments. Thus, the matter to be addressed is such reports. For these reports to be the basis for comparisons among institutions, the institutions that are to be compared must submit reports that are uniform. But this does not mean that every hospital in the United States must submit its report on an identical form or basis, because meaningful comparisons cannot be made between a 10-bed rural hospital with simple services and a 1000-bed medical center. Similar institutions should, however, report similarly. Data suitable for uniform reporting should be collected for that purpose, and we do not argue against further appropriate accounting requirements that are needed to yield uniform reports. However, establishment of uniform accounting requirements that go beyond the need is not good in itself. Where accounting requirements unrelated to a known objective are imposed, they are likely merely to increase accounting costs to no advantage. We urge that requirements of this sort be rejected as counterproductive to our efforts to reduce health care costs.

While the proposed language for amending Title XVIII of the Social Security Act (Medicare) suggests use of the uniform accounting system that would be mandated for Medicare and Medicaid reimbursement for such other purposes as income tax reports, SEC reports, internal management reports, and corporate reporting to stockholders, a system developed for reimbursement is not likely to be suited to these other uses. Imposition of new requirements will thus be costly and involve the use of more than one accounting system by many hospitals.

A large Portland, Oregon, accounting firm recently undertook a study of the hospital costs that would be associated with conversion to a uniform functional accounting system such as this bill proposes. Their study reports that costs of such conversion range from $5,000 to $50,000 for a single hospital, and that the typical cost would be $20,000. On a national basis, the total conversion cost would be $140 million, and this does not include the significant cost of maintaining a separate system for internal management control purposes.

UNIFORM PRODUCTIVITY MEASURES, DISCHARGE ABSTRACTS AND BILLING

There is very limited capacity and knowledge for measurement of the productivity of health care services, which the bill proposes be undertaken. For example, there is limited capacity to measure the success of curing illness and there is virtually no measure for the degree to which the pain of those who cannot be cured is eased. Although some measures of input and output exist for some operations and cost centers, they are at best, only indicators that often change as a result of changes in technology and medical practice.

Application of uniform measures of productivity, assuming their feasibility, would require the collection and reporting of difficult statistics which would be very costly, particularly to ensure reliability and validity. In addition, such an effort would duplicate and replace existing specialized methodologies and systems in many hospitals without any recognizable benefit to the hospital or to the community at large. Clearly, the cost of this proposal would far outweigh its potential benefits.

The bill also proposes establishment of a uniform discharge abstract. The American Hospital Association has long been on record as opposing a uniform abstract for collecting patient discharge data, yet we do support the establishment of an appropriate compilation of uniform discharge data and standard definitions. The specification of a uniform data abstract form would necessarily require hospitals to incur costs in converting from existing systems designed for their use to new systems to meet the new requirements proposed in the bill. In most cases, hospitals, using existing data systems, are capable of and already do collect the necessary data required by a multitude of federal and state agencies. Here too, we must caution you concerning the considerable additional expense in system conversion and duplicate data preparation. The American Hospital Association has long supported the concept of a national uniform billing system. Since 1968, we have worked with representatives of the Bureau of Health Insurance, Social and Rehabilitation Service, and other third-party payer groups to get acceptance of one billing form that would save millions of health care dollars annually. I must point out, however, that it has not been hospitals who have delayed the implementation of this uniform bill. Rather, the government, with its ever-increasing complexities in state and federal regulations, has prevented its easy development and implementation. We support continued efforts to finally achieve this goal. The remaining problem hindering the necessary cooperation of all payers is found in Medicaid. If legislation can resolve this issue, we would be most happy to cooperate in its development.

In view of the above, we are opposed to H.R. 4211 in its present form. You may be sure, however, that we stand ready to assist in any way we can to modify the bill to facilitate its purposes of improving the accuracy of reimbursement determinations and improving our ability to compare like institutions that provide like services.

We will be pleased to respond to any questions from the Committees.

Mr. ROGERS. As I understand it, you do support H.R. 3. I thought the American Hospital Association had recommended a uniform system of accounting to its members. Have you not?

Mr. MANZANO. The definition of uniform accounting, I think, is the issue which we have to address. The American Hospital Association has published a chart of accounts which is available to hospitals in establishing their accounting systems.

However, the chart of accounts is applied by the hospitals to reflect their particular organization and the particular mix of services they present. The problem with going beyond that to impose a uniform system that all hospitals would have to use suggests that the kind of detailed reporting, the kind of accounting records would have to be identical from institution to institution.

This would not be purposeful, because hospitals are different. They have different services and they are organized differently.

Now there is a body of uniform reports which we think are entirely appropriate, and there needs to be, of course, a means to collect that data in such a way so it is reported meaningfully to whoever requires the data. We have supported uniform reporting. I think that to proceed——

Mr. Rogers. I thought you went beyond uniform reporting. You recommended the uniform accounting systems, did you not, to your members?

Mr. Manzano. No, sir.

Mr. Rogers. Never?

Mr. Manzano. No, sir.

Mr. Rogers. Some of the hospitals told me that you did. You never recommended the uniform system?

Mr. Manzano. No, sir.

Mr. Rogers. What is it that you have recommended? Other than just the reporting?

Mr. Manzano. Well, we have basically provided them a tool for them to use in establishing accounts, but they may use it in accordance with their own internal and functional needs.

Mr. Rogers. I understand. You recommended it to them, didn't you? You said it is up to them to use it, but you recommended it is a useful tool, didn't you?

Mr. Manzano. Mr. Chairman, I would like to describe, for instance, a couple of situations where you might see where there would be a difference in how accounts would be set up.

A hospital, for instance, may not have in its operation an intensive care unit. It would not use, therefore, anything that collects data on that kind of operation.

Mr. Rogers. What hospital would?

Mr. Manzano. Well——

Mr. Rogers. If you don't have the service, you don't have to have that accounting system, I presume. I think that's common sense. What else?

Mr. Manzano. Well, there's a—the level of detail that this bill suggests, for instance, requires that there be postings to particular subaccounts. Subaccounts may or may not be useful in an institution, depending upon its own internal accounting needs. Accounting is primarily designed to provide an internal management report so you can tell how well a manager is doing, what he is spending on, what he is not spending on. It reflects to a large degree the structure and organization of that institution.

Now I don't think the issue is whether or not the hospitals are reporting identically or accumulating data identically for purposes of reports. I think clearly we would not have any problem with that. The problem is if you require the hospitals to post and install a detailed accounting system——

Mr. Rogers. Let me add this:

You can have them all report what is the cost for a day's stay in the hospital. You could have them all report a certain item to you. But if making up that item is not the same as given in the testimony by Congressman Moss, whether you do it by units of radiation or just patient days, then what happens?

Mr. Manzano. Congressman Moss, and I believe you have also cited the California system which does have under its cost disclosure act——

Mr. Rogers. I don't think he cited that as necessary. He said they did have a system.

Mr. Manzano. He also cited, I believe, the Washington system. In these States there is a State-defined system for reporting and there is a State-defined accounting program.

That accounting program, like the one that is proposed here, is functional in nature and what occurs in those hospitals is that they keep their accounts on a day-to-day basis as they have always done. They reconcile to the State-imposed functional accounts once; and from that, they then submit their reports.

The way this bill approaches it, at least within the context developed in 1533(d), it woud go the other way. The hospitals would be required to do day-to-day accounting in accordance with the bill, reconcile monthly to their own internal accounting needs. We think that is backwards.

Mr. Rogers. I am not sure. I think there is a great deal of flexibility..

I might say, too, the Washington State Cost Commission, rather than having the experience you seem to think may come out of it, showed that for some $35,000, where the comptroller of the hospital spent, they saved $350,000 because it helped them with internal matters.

Mr. Manzano. I think you are talking about the one example cited by Congressman Moss. I don't know whether that example would reflect the situation in most institutions whereby a conversion of accounting systems would suddenly reveal a whole bunch of areas requiring that there be management changes to generate that kind of savings.

Mr. Rogers. Might I say you might look at it because I think you might be surprised that it might well happen, because in some of the experiences I have seen where you have for-profit organizations vis-a-vis some nonprofits, we find some rather different experiences. It might be well for us to look at that. I would hope you would before you get your position in concrete.

Dr. Gehrig. If I could go up just one step further on that, I would like to be very sure that we are clear. If the basic purpose here is in fact to get data which has substance in terms of being uniformly collected and uniformly reported, we have agreed to that. Our point of resistance is the matter of a prescribed uniform functional accounting system.

What we are really saying—and I believe you will find there will be testimony from other people not related to the hospital industry that supports this—that the purpose you seek can be achieved within present systems that now provide the flexibility not only for governmental reporting for SEC and for a host of other Federal agencies, but in fact provides the management its tool.

When you use a specific and single instance that management save $350,000 in its conversion, I would submit, while I have nothing to back this up, that effective hospital management in many areas, because they have designed systems which meet their management needs and prerogatives are in fact saving money you are not aware of.

Further, the comparison of a one-time investment with some saving as was suggested is inadequate because therewill be in our judgment and from our discussion with institutions a continuing operational cost for two separate systems.

I think the AHA is not that far from your goal, but we do believe that a major mistake is being made if you put this uniform and rigid accounting system requirement in.

Mr. ROGERS. Well, I am not sure that the—that you properly interpret the intent of the bill. I think we better look at that. We will have discussions with you. I would hope that you would have discussions with the staff, see what the intent is, because I am not sure you have interpreted the intent correctly.

Mr. MANZANO. We will.

Mr. ROGERS. Mr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

It is certainly good to see you gentlemen this morning.

Some witnesses have expressed concern about involving PSRO's in the review of shared health facilities. What is your position on this issue?

Dr. GEHRIG. Basically in our comments we did not object to the bill which in a sense provided the Secretary apportunity to give a priority to a request from a PSRO to review the medical mill or the shared health facility. We have not objected to that. There is in the bill, in our judgment, a possibility for misunderstanding that there is a change of authority so that the Secretary could initiate such review on his own.

I believe the original legislation—I have assumed the intent of this bill is merely to permit the Secretary an opportunity to establish a priority where the PSRO has requested such authority.

Mr. CARTER. Do you think the State agencies would be better equipped to assume this responsibility?

Dr. GEHRIG. Of the PSRO review for this activity?

Mr. CARTER. Yes.

Dr. GEHRIG. We are really anxious, Mr. Carter, to finally get someone who does the review. We supported generally PSRO and institutional review. We are presently concerned because of what has been really a dual review in some areas.

I would suggest that while we don't address it specifically, that we do support the PSRO review of these types of facilities where it is requested.

We are delighted with another aspect of the bill, which provides that where a conditional PSRO review is considered adequate, no other conflicting review need be continued.

Mr. CARTER. Are you concerned that the bill's proposed emphasis on ambulatory care will detract from PSRO's ability to review the in-patient care adequately?

Dr. GEHRIG. I believe as long as the PSRO has—and we are going to assume they will be responsible bodies—the right to request an extension of their authority, that they will hopefully only do it in those areas where they are on top of the job that they are already doing, that is in patient review. I would hope that the way the mechanism is set up, which does not mandate it, will permit a PSRO only to bite off additional work as it has the capacity to assume it.

Mr. Carter. Thank you, Mr. Chairman.

Mr. Ottinger [presiding]. I have no further questions.

Do you have a question, Mr. Duncan?

Mr. Duncan. I would like to compliment both of you gentlemen for your fine statements; and I think you well understand the problem and also you well understand the subject matter as well as any witnesses we have had.

Is there anything that the hospitals can do? Can you do anything better to help control unnecessary hospitalization and procedures? I know sometimes you have difficulty with the physicians in scheduling their time and surgery and so forth. Is that a problem that you can do anything about?

Dr. Gehrig. Yes, Mr. Duncan. Really our feeling has been that—but could I say first we are unusually sensitive to the cost problem. We are trying everything we can that directs itself at cost. We have supported certificate of need and other things aimed at controlling capital investment on the one side.

On the other side is the area you mentioned of utilization. Here we have prior to the PSRO enactment in the Social Security Act developed an institutional review program which now links itself with PSRO. We believe it is this peer review that has to get off the ground to be effective in controlling the institutional use.

Mr. Duncan. Do you think perhaps that the matters such as developing uniform accounting system and adequate control might be better considered in other legislation? It was suggested by someone, perhaps the Chairman, earlier—other than the legislation on abuse and fraud?

I know the administration apparently is recommending something on cost control. Do you think we might better cover that in that proposed legislation rather than the abuse and fraud bill we are into now?

Dr. Gehrig. Mr. Duncan, I think you have stated very clearly the feeling that we have, which is that this issue could better be considered, as I believe Chairman Rostenkowski indicated earlier, in the later social security legislation. I do state beyond that—and we have placed our position as clearly as we are able, that we are opposed to the inclusion of a uniform functional accounting system at any time, but we do believe that discussions of it might well be more appropriate in the subsequent reform legislation.

I would like to ask Mr. Manzano if he has something to add to that.

Mr. Manzano. In the course of the preceding testimony, I believe Congressman Moss identified one of the problems was accumulating data so they could identify what the problems were. I think a previous testimony indicated they were unable to collect information to establish profiles of patients and providers.

The data for the establishment of these profiles is in fact already provided through the claims system data. The problem is not that the data is not being provided. The problem is being able to manipulate the data in such a way that you can publish meaningful reports and accumulate from many records the picture of a particular beneficiary on behavior of a provider. That is not going to be helped by any uniform accounting system.

A lot of the data actually specified in this bill is already present, to a large extent. For instance, within medicare and medicaid, there is in effect a uniform bill today. That is the data which is provided in the medicare claim form which most medicaid programs also use. The information that is required for abstracting of health care is largely also present today in the claim form.

There is, in effect, a uniform report specified today in the nature of the medicaid cost which is a uniform report as you have nationally.

I think the point is that someone ought to, I think, pay attention to what are the meaning ful reports that are needed at the tail end for purposes of surveillance and review.

I am afraid that the emphasis is being given to the development of very large expensive systems without any clear perception of how they will be used finally. I think that's the point.

Whatever can help to develop useful information and useful reports, I think is absolutely correct; but to specify generic adoption of things like productivity measures, generic adoption of massive reporting and massive revision to accounting systems, where there's never been a demonstration of even the nature of the reports that will be required, much less how they will be used, I think is a problem.

Today there are examples of reports from a financial product in California and Washington that has been specified. I have yet to see how those have been used in any meaningful way by the reimbursement programs. They were essentially designed for public disclosure of costs or for the development and use of a rate review. system. That's not the same thing that is being discussed here.

Mr. Duncan. You indicated, I think, in your words, that we have hospitals and we have hospitals giving different kinds of services and supplying different needs.

Mr. Manzano. Yes.

Mr. Duncan. Don't you think perhaps we should have a different reporting system for smaller hospitals than the larger hospitals?

Mr. Manzano. Yes, I do.

I think that a lot of reconciliation can be made between various similar hospitals through the design of the reporting system, but that you don't need detailed accounting systems within those hospitals which are absolutely identical.

Mr. Duncan. Thank you, gentlemen.

Thank you, Mr. Chairman.

Mr. Rogers [presiding]. Thank you very much for being here. We are grateful to you. We would be glad to have you be in touch with the committee on the uniform accounting provisions.

The next witness will be the Blue Cross Association.

Your statement will be made a part of the record in full.

STATEMENT OF D. ANN SALADINO, SENIOR DIRECTOR, HEALTH CARE SERVICES, BLUE CROSS ASSOCIATION

Mrs. Saladino. Thank you, Mr. Chairman, distinguished Chairman, members of the joint committees, I am Ann Saladino, senior director of the Blue Cross Association, the national coordinating agency of the 70-member Blue Cross plans in the United States and Puerto Rico.

The association is a prime contractor to SSA for the medicare program. Individual Blue Cross plans are subcontractors to the association for this program and many also administer the medicaid program in their territories.

I thank you for this opportunity to offer our views on the medicare and medicaid antifraud and abuse amendments, H.R. 3.

It is regrettable that such legislation is necessary, but the reality is that the sheer magnitude of the medicare and medicaid programs increases the potential for fraud and abuse. In addition, the age, physical condition, and socioeconomic dependency if beneficiaries of both programs compounds the problem. However, the vast majority of providers are honest and we believe they will support your efforts to eliminate fraud in the health care delivery system.

We believe that abuse stems largely from provider misinterpretation and regulations, lack of appropriate incentives or regulatory gaps.

We are in full support of legislation and programs aimed at insuring that money is not paid to ineligible persons or institutions and that appropriate actions are taken against those in violation of the laws.

The Blue Cross Association and the Blue Cross plans are committed to overall cost containment in the health care delivery system. Fraud and abuse detection investigation and ultimate resolution are vital elements in any strategy to safeguard the integrity of the total health care dollar.

Our comments on specific section of H.R. 3 are based on the preceding general comments with particular emphasis on medicare and medicaid programs costs—both administrative and benefit.

While more detailed comments have been submitted for your consideration, I would like to highlight some points at this time.

We support the prohibition against assignment by physicians and others for services. While it does not provide a foolproof solution, it should reduce the opportunity for fraud and abuse.

We support the disclosure of ownership and financial information, recognizing the need for Government to have access to information about the services for which it pays. We feel due cause should should be shown in making requests for information.

Where potential fraud and abuse has been detected, Government ought to have the latitude to obtain any information it considers necessary. Therefore, the words in section 1124(a)(1)(D) "as to any significant", should perhaps be replaced by "as to the nature or extent of." Further revisions might also be necessary to allow Government to obtain information about any transactions between or among persons and/or entities or organizations owned or controlled by persons identified in section 1124(a)(1)(C).

I think that is the cross-reference you were talking about earlier.

The definition of "shared health care facility," while improved in this version, still lacks clarity. The legislative intent is to require disclosure of information about so-called "medicaid mills." However, section 1125(3)(A) could be interpreted to include all group practices which retain business or administrative managers.

There are shared health facilities and group practices which are quite ethical and do serve the public interest. We do know, however, that the most common features of the medicaid mills are as described in your new section 1125. The shared health care facility which is a target for fraud and abuse investigation is likely to be an extremely complex network of individuals, business and professional entities and services all motivated for quick and substantial profit. The full weight of Government and its contractors' audits should be focused on the parties committing offenses. For this reason, we hope that in your committee report you will clarify that the definition applies to providers in situations where there is evidence of wrongdoing.

We support the more stringent penalties for defrauding medicare and medicaid programs.

We support the focus of PSRO's on cases of suspected fraud and abuse. The major value of the PSRO program is that it formalizes peer review in Government programs for the purposes declared in section 1151 of this act.

While we have supported the PSRO program from the outset, we have concerns about how it is evolving in practice. There is much evidence of a lack of coordination between Government agencies and the private sector, resulting in a costly confusion of roles and responsibilities among hospitals, PSROs and fiscal intermediaries. While this is still an evolving program, much potential effectiveness seems to be being lost.

There are two aspects of H.R. 3's section 5, which we believe are of major significance. One: Mentioned at the outset, is that PSRO's will bring their professional expertise to bear on cases of fraud and abuse. The other is the recognition of the great need for evaluation of PSRO effectiveness. We strongly endorse this move to formalize the PSRO evaluation process as a priority item.

As intermediaries, we are concerned with the lack of final regulations and instructions for most of the activities of current practice. As private third party payors, we have long supported peer review mechanisms and believe PSRO's could be utilized in our private business where there is demonstrated effectiveness. We, therefore, have a vital interest in Government's diligent evaluation and judgment of the cost and quality of the USRO program.

Many of the amendments related to PSRO's in H.R. 3 affirm current practices but because of existing gaps in coordination and regulations, we are concerned that the changes may not be accomplished as readily as you would hope or expect.

The following comments address certain specifics in H. R. 3:

We strongly support the reaffirmation of the scope and limitations of PSRO responsibility in the first section.

The bill would make it easier for PSROs to attain designation by the Secretary as "qualified" by omitting the requirements for proven capability in long-term care review. However, while omitting long-term care review, the amendment adds ancillary services. This addition could thwart the intent of the legislation to moke the "qualified" designation easier to attain. Ancillary review, like long-term care review, is difficult to do on a concurrent basis and has no established and proven methodologies.

We recommend that the amendment be revised to allow qualified designation for at least basic hospital review while other review activities, such as ancillary and long-term care review could be added with temporary conditional designation.

Further, we understand the intent of the relaxation of the requirement is to make review possible in rural areas where the only doctors also own the hospital. It would be better to specify this as an exception rather than allow review by financially interested physicians as a general condition.

We support the intent of patient medical information. However, we urge Congress to build in some tests of reasonableness. Duplication of existing data systems should be carefully avoided.

The bill appears to require the Secretary to provide by regulation for the establishment of a new data collection system separate from the PSRO management information system. We recommend any such duplication, if that is in fact the intent.

Currently, the National Professional Standards Review Council must submit an annual report, to both the Secretary and the Congress. Unfortunately, the annual report appears to be based on the new data system in subsection (h). We support the requirement that the Secretary submit such an annual report drawn from existing data sources.

Giving priority to PSRO requests to review services provided by shared health care facilities could have the possible effect of limiting expansion of PSRO activity into broader program areas of cost and quality.

We recommend that the proposed section 5(d)(4) be added as a subsection of 1155(g) which establishes priorities for the PSRO program, but does not exclude review of other health care services.

We support section 5(i)(4) which requires PSRO's to furnish data for purposes of fraud and abuse investigations and health planning.

We support section 5(m) which places part B services under PSRO review authority. It is an important recognition of the need to link inappropriate hospital use with inappropriate physician services.

Moving to the remaining sections of the bill, we recommend that the intended scope of the subpena power by the Comptroller General be clarified in the committee report and that a reasonable expectation of wrongdoing be established as grounds for use of the subpena power.

Suspension of practitioners convicted of medicare- or medicaid-related crimes. We support this section. However, the suspension from participation in the program in and of itself does not protect the public from continuing fraudulent and abusive practices by the practitioners. Since suspension does not affect licensure, inappropriate, unnecessary and excessive care can still be rendered and billed directly to the unsuspecting patient. Under these circumstances, we would recommend that there be full and complete disclosure of a practitioner's suspension to the public.

We believe the bill's section on disclosure by providers of owners convicted of certain offenses may be too general. The indirect ownership or control interest and conviction history of an individual may not be known to the provider in question. Providers who have not knowingly concealed or misrepresented the facts should not suffer the same consequences as those who fail to disclose known information.

Section 9 and 10 of your bill, we support. In the final section, I would like to note that we see the practical effect of this section on medicaid as the payor of last resort as one which might override State statutes and private contracts for the purpose of providing a third party liability. We question the public policy justification for a Federal statute that contravenes a provision of State and/or private negotiated contracts. In the case of private contracts, the provision creates a form of double taxation wherein private subcribers are required to support the Federal medicaid program through both income tax payments into a general fund as well as premium payments for a private contract.

In conclusion, we feel the H.R. 3 amendments are a positive step in the right direction, in adding means for detecting, focusing the professional expertise of PSRO's on the investigation, and providing more stringent penalties and consequences as deterrents to perpetrators of fraud and abuse in Federal health care programs.

We applaud your efforts to maintain the public trust and thank you for the opportunity to offer our comments.

Mr. Rogers. Thank you, Ms. Saladino. I think it would be helpful if you could perhaps give us some suggested language for a better definition for shared health care facility, if you could do that. Not now, but for the record.

Ms. Saladino. We would be happy to.

[The prepared statement and subsequent submission of suggested language changes follow:]

STATEMENT OF THE BLUE CROSS ASSOCIATION AS PRESENTED BY D. ANN SALADINO, SENIOR DIRECTOR, HEALTH CARE SERVICES

Mr. Chairman and Members of the joint Committees. I am Ann Saladino, Senior Director of the Blue Cross Association, the national coordinating agency of the 70 member Blue Cross Plans in the United States and Puerto Rico.

Pertinent to this hearing, the Association is a prime contractor to the Social Security Administration for the provision of nationwide intermediary services under the Medicare program. Individual Blue Cross Plans are subcontractors of the Association for this program.

Many of our Plans also administer the Medicaid program in their territories.

I thank you for the opportunity to share with you our views on the Medicare and Medicaid anti-fraud and abuse amendments, H.R. 3. In our review, we have also considered the related Senate bill, S.143.

Many of the provisions of these bills were contained in the earlier bills, H.R. 12961 and S. 3205, on which we offered comments in detail. I refer interested persons to our previous statements dated July 30, 1976, and September 24, 1976, for background information on issues related to matters now before these committees. Our prior comments and those to follow illustrate our continuing concern for and support of the intent of these bills.

That intent, best set forth in H.R. 3, is "to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs and for other purposes." It is regrettable that such legislation is necessary, but the reality is that the sheer magnitude of the Medicare and Medicaid programs increases the potential for fraud and abuse. In addition, the age, physical condition and socioeconomic dependency of beneficiaries of both programs compounds the problem. However, we know that the vast majority of providers are honest and believe that they will support your efforts to eliminate fraud and abuse in these health care programs.

We also believe that outright fraud is of much less magnitude than abuse. Abuse stems largely from provider misinterpretation of law and regulations, lack of appropriate incentives, or regulatory gaps.

We are in full support of legislation and programs aimed at insuring that money is not paid to ineligible persons or institutions and that appropriate actions are taken against those in violation of the laws.

The Blue Cross Association and the Blue Cross Plans are committed to overall cost containment in the health care delivery system. Fraud and abuse detection, investigation and ultimate resolution are vital elements in any strategy to safeguard the integrity of the total health care dollar.

Our comments on specific sections of H.R. 3 are based on the preceeding general points, with particular emphasis on Medicare and Medicaid program costs—both administrative and benefit.

SECTION 2. PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS FOR SERVICES

We support this provision. While it does not provide a foolproof solution, it should reduce the opportunity for fraud and abuse because it clarifies the illegality of factoring or use of powers-of-attorney agreements.

SECTION 3. DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

Recognizing the need for government to have access to information about services for which it pays, we support this section.

Our specific comments relate to the clarity of definition, scope of effort and administrative implications for both government and providers who are without fault.

While the provisions on disclosures have been substantially improved over previous proposals, they still leave considerable latitude for the Secretary and/or Comptroller General to make requests for information without cause.

Section 1124 applies to any request made for information, although it appears that information would be necessary in only three circumstances:

1. Suspected fraud or abuse.
2. Misapplication of the prudent buyer principle—that is, situations where excessive costs are incurred arising out of poor business practice or conflicts of interest.
3. Dealings between related organizations—where business is transacted between two entities which have common ownership or control and therefore normal arms-length business dealings may not take place.

To protect related organizations against unwarranted and excessive requests for information, it would appear appropriate to limit the circumstances under which such requests could be made.

Qualifying language is needed to limit requests to those where a showing of cause can be made and to establish a more reasonable level of reporting. In Section 1124(b), after the phrase "promptly comply with any request," we suggest adding the phrase "accompanied by a showing of cause."

We have general concern about what might constitute "significant business transactions" in Section 1124(a)(1)(D). Where potential fraud and abuse has been detected, government ought to have the latitude to obtain *any* information it considers necessary. Therefore, the words "as to any significant" in paragraph (D) should perhaps be replaced by "as to any significant" in paragraph (D) should perhaps be replaced by "as to the nature of extent of." Further revision might also be necessary to allow government to obtain information about any transactions between or among persons and/or entities or organizations owned or controlled by persons identified in Section 1124(a)(1)(C). More precise reporting requirements could then be identified through regulations.

The amount of time allowed for furnishing information appears to need clarification as do the bases for suspension of payments and contract termination. The use of the verb "may" implies a choice of pursue or not. We are not clear whether this is the intent, but recognize that it may well be deliberate wording to establish the option as a warning and the most administratively feasible approach. A blanket mandate could result in a high volume of non-cost effective efforts. We support this discretionary approach but hope that regulations will focus on specific areas where present experience or new evidence indicates problems, with reporting mandated for them.

The bill should perhaps indicate that any potential for reinstatement of provider status is contingent upon compliance with a set of regulations that are specific to situations of provider status lost through fraud and abuse. Such regulations should also require a period of special reporting and monitoring for any providers who have been reinstated.

As we said about the earlier bill, H.R. 12961, the definition of "shared health care facility", while improved in this version, still lacks clarity. We understand that the legislative intent is to require disclosure of information about so-called "Medicaid Mills." Section 1125(3)(A), however, could be interpreted to include all group practices which retain business or administrative managers.

We recognize the difficulty in defining share health care facilities in such a way that it will include only the illegal and unethical. There are shared health facilities and group practices which are quite ethical and serve the public interest. We do know, however, that the most common features of the Medicaid Mills are as described in your new Section 1125.

The shared health care facility which is a suitable target for fraud and abuse investigation is likely to be an extremely complex network of individuals, business and professional entities and services all motivated for quick and substantial profit. The full weight of government and its contractors' audits should be focused on the parties committing the offenses. For this reason, we hope that in your Committee Report you will clarify that the definition applies to providers in situations where there is evidence of wrongdoing.

SECTION 4. PENALTIES FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

We support this section with its more stringent penalties for those found guilty of fraud and abuse. The effects of this judgment on a practitioner's or entity's future participation and the terms of it may need to be addressed in your Committee Report to more clearly tie in all related sections of H.R. 3.

SECTION 5. AMENDMENTS RELATED TO PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

We recognize the appropriateness of having the professional resources of Professional Standards Review Organizations (PSROs) focus special attention on cases of suspected fraud and abuse.

The major value of the PSRO program is that it formalizes peer review in government programs for the purposes declared in Section 1151 of the Act. While we have supported the PSRO program from the outset, we have concerns about how it is evolving in practice. Government health care programs need to make the most effective use of this professional expertise.

There is much evidence of a lack of coordination between government agencies and the private sector, with a resultant lack of clarity about roles and responsibilities among hospitals, PSROs and fiscal intermediaries. While we realize that this is still an evolving program, much potential effectiveness is, in fact, being lost.

There are two aspects of H.R. 3's Section 5 which we believe are of major significance. One, mentioned at the outset, is that PSROs will bring their professional expertise to bear on cases of fraud and abuse. The other is recognition of the need for evaluation of PSRO effectiveness. We strongly endorse this move to formalize the evaluation process as a prority item.

As intermediaries, we are concerned with the lack of final regulations and instructions for most of the activities of current practice. As private third party payers, we have long supported prereview mechanisms and believe PSROs could be utilized where they have demonstrated their effectiveness. Many Blue Cross Plans are considering or are currently involved in pilot projects of this nature. Our private business use of PSROs must be structured to safeguard our subscribers dollars—both benefit and administrative. Therefore, apart from our intermediary concerns, we have a private business interest in government's diligent evaluation and judgment of the effectiveness of the PSRO program—in terms of both cost and quality.

Many of the amendments related to PSROs introduced in H.R. 3 affirm current practices but because of existing gaps in coordination and regulations, we are concerned that the changes may not be accomplished as readily as you would hope or expect. We pledge our continued support to resolve these difficulties and further the intent of the PSRO program and the present amendments.

The following comments address certain specific in H.R. 3.

1. We support Section 5(a) which says that where PSROs are found competent and are delegated review responsibility by the Secretary, PSRO determinations of medical necessity, quality and appropriateness shall constitute the conclusive determination for purposes of payment. This section affirms current practice. This particular affirmation of PSRO authority seems to be an improvement over earlier versions because it specifies that other requirements with respect to eligibility or payments for benefits must still be satisfied. Therefore, it is clear that the Intermediary would retain responsibility for claims review to determine eligibility, technical coverage issues and allowable costs and to monitor as required by the Secretary.

2. Section 5(b) would make it easier for PSROs to attain designation by the Secretary as "qualified" by omitting the requirement for proven capability in long-term care review. However, while omitting long-term care review, the amendment adds ancillary services. This addition may thwart the intent of the legislation to make the "qualified" designation easier to attain. Ancillary review, like long-term care review, is difficult to do on a concurrent basis and has no established and proven methods. Requiring ancillary review capability in order to be designated "qualified" could push PSROs eager for such status into costly and untested ancillary review systems, with the high probability of additional PSRO duplication of the data collection activities of the Intermediaries. Congress should assure that ancillary review is as efficient and as cost-effective as possible before "qualified" designation is given and monitoring by Intermediaries ceases.

We recommend, in the interest of further developing PSRO capability, that the amendment be revised to allow "qualified" designation for at least basic hospital review while other review activities, such as ancillary and long-term care review could be added with temporary conditional designation to permit an orderly and rational development period.

3. Subsections (d)(1) and (d)(2) loosen the conflict of interest provisions, both on a financial level and on a patient care level. The requirement that physicians conducting PSRO review in a given hospital have no financial interest in that hospital would be changed to no significant financial interest. The requirement that a review physician not be directly or indirectly involved in the patient care being reviewed would be changed to not directly responsible for the patient care being reviewed. We do not believe these changes are wise.

We understand that the intent in relaxing the requirement is to make review possible in rural areas where the only doctors available also own the hospital. It would be better to specify this as an exception rather than allow review by financially interested physicians as a general condition. Allowing physicians to review in hospitals where they have a financial interest will further decrease the possibility of objective review. As "significant" is subject to varying interpretations, the call for "no significant financial interest" is no safeguard.

4. In Section 5(c) we recognize the need for PSROs to have access to the records of providers under review and to be able to abstract necessary patient care information. Our basic concern with this amendment is the possibility of of ever-expanding, duplicative data systems which it opens up. Because of the volume of abstracts potential in ambulatory care review systems, we urge the Congress to build in some tests of reasonableness to assure that the costs are appropriate to the benefits attained.

5. Section 5(h) appears to require the Secretary to provide by regulation for the establishment of a new data collection system separate from the PSRO Management Information System. If this is indeed the intent of the amendment, then we recommend against it because we have repeatedly taken stands against duplication of data collection systems.

Incorporating this provision in Section 1165, which requires the Secretary to provide for the coordination of data gathering activities among PSROs, Intermediaries and other agencies to avoid costly duplication of data gathering efforts, could create a contradiction within the law.

However, we certainly are in favor of the Secretary assuring that data necessary to evaluate PSROs objectively and on a timely basis are available. We believe this authority is already present in Section 1165. Timely and consistent regulations could accomplish your objectives in this section.

6. We support Section 5(1). Currently, the National Professional Standards Review Council must submit an annual report, with few required elements, to both the Secretary and the Congress. We recognide the right, or perhaps the obligation of the Congress to know the impact of its legislation. The detailed specifications in the required annual report are not excessive, although "(6) changes in utilization rates and patterns, and changes in medical procedures and practices attributable to the activities of the PSROs" will be difficult to determine. It is, however, the basic question in PSRO program evaluation. Unfortunately, the annual report appears to be based on the new data system in (h). We support the requirement that the Secretary submit such an annual report drawn from existing data sources and that evaluation be diligently pursued by government.

7. Subsection (d)(4) strike out 1155(g) which requires that PSRO review be limited to services in institutions unless a PSRO specifically requests the responsibility to review other health care services, e.g., ambulatory care. The proposed new section 1155(g) states that the Secretary must give priority to PSRO requests to review services given in shared health facilities (meaning "Medicaid Mills").

We support the intent of this language to focus new PSRO activity on an area of potential fraud and abuse. However, a possible effect of this new emphasis may be to limit expansion of PSRO activity into broader program areas of cost and quality. The need for new review mechanisms for ancillary services, new technology and long-term care must also be weighed in considering limitations on the scope of PSRO activity. We recommend that your Committee Report clarify your intent with respect to the potential limitations on the PSRO program implied by this section.

We wonder if the intent of Congress is to limit the scope of PSRO review and focus it on problem areas such as shared health care facilities. The intent of this limitation should be clarified. While it would increase the role of PSROs in correcting abuses under the current Medicare and Medicaid programs, this limitation could limit the potential usefulness of PSROs in the broader program issues of cost and quality. The need for review mechanisms for ancillaries and new technology must be weighed in considering this limitation on the scope of PSRO activity. We recommend that the proposed Section 5(d)(4) be added as a subsection of 1155(g) which establishes priorities for the PSRO program, but does not exclude review of other health care services.

8. We support Section 5(i)(4) which require PSROs to assist appropriate State and Federal agencies in fraud and abuse investigations by providing data and also gives them a similar role in assisting health planning agencies.

9. We support Section 5(m) which would place Part B services under the review authority of PSROs. It is an important recognition of the need to link inappropriate hospital use with inappropriate physician services. PSROs should make a major contribution in this area. We only urge that the ultimate processes to accomplish this should be put to a cost-effectiveness test in the development stage rather than post facto. The Blue Cross Association has some experience in this type of linkage in our private business processes and would be pleased to lend its support in this endeavor.

SECTION 6. ISSUANCE OF SUBPOENA BY COMPTROLLER GENERAL

We fully support any step which could increase the government's access to information which is necessary to detect and confirm fraudulent and abusive actions.

This section gives a power to the Comptroller General that has the potential for extremely broad application. We recommend that the intended scope of that power be clarified in the Committees Report and that a reasonable expectation of wrong-doing be established as grounds for use of the subpoena power.

As we have said before, the multiplicity of agencies and entities focusing on the investigation of fraud and abuse will require close coordination. This is necessary for two important reasons:

1. Shared information and strategies for investigation can expedite the most timely, comprehensive and cost-effective detection and prosecution of fraud and the correction of abuses.

2. Joint efforts among those responsible for government program integrity will eliminate many unnecessary or duplicative intrusions on the operations of legitimate providers and, since they are more likely to reveal gaps in program policy and in providers' understanding of the programs, reduce the incident of non-intentional abuse.

SECTION 7. SUSPENSION OF PRACTITIONERS CONVICTED OF MEDICARE—OR MEDICAID—RELATED CRIMES:

We support this section. However, the suspension from participation in the program in and of itself does not protect the public from continuing fraudulent and abusive practices by the practitioners. Since suspension does not affect licensure, inappropriate, unnecessary and excessive care can still be rendered and billed directly to the unsuspecting patient. Under these circumstances, we would recommend that there be full and complete disclosure of a practitioners' suspension to the public. Subsequent regulations should address the duration and terms of the suspension.

SECTION 8. DISCLOSURE BY PROVIDERS OF OWNERS CONVICTED OF CERTAIN OFFENSES

While such disclosure is essential, this section is too general. The indirect ownership or control interest and conviction history of an individual may not be known to the provider in question. Providers who have not purposefully or knowingly concealed or misrepresented the facts should not suffer the same consequences as those who fail to disclose known information.

SECTION 9. FEDERAL ACCESS TO RECORDS

We support these changes.

SECTION 10. CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS FOR MEDICAID PROGRAMS

We support this change.

SECTION 11

The practical effect of this provision is that it overrides State statutes and private contracts for the purpose of creating a third party liability. We question the public policy justification for a federal statute that contravenes a provision of State and/or private negotiated contracts. In the case of private contracts, the provision creates a form of double taxation wherein private subscribers are required to support the federal medicaid program through both income tax payments into a general fund as well as premium payments for a private contract.

Currently, Section 1902(a)(25)(A)(B) and (C) provides for assurances that all reasonable measures are taken to ascertain the legal liability of third parties where it does in fact exist. It is our understanding that States have not uniformly implemented third-party programs to identify Medicaid costs payable by a third-party. The HEW guidelines published in June of 1976 were designed to help States institute comprehensive third-party liability programs.

CONCLUSION

The Medicare-Medicaid Anti-Fraud and Abuse Amendments contained in H.R. 3 are a positive step in adding means for detecting, focusing the professional expertise of PSROs on the investigation, and providing more stringent penalties and consequences as deterrents to perpetrators of fraud and abuse in federal health care programs.

We applaud your Committees' efforts to maintain the public trust and thank you for the opportunity to offer these comments.

DEFINITION OF SHARED HEALTH FACILITIES

The Blue Cross Association has again analyzed the language of H.R. 3 as it pertains to the definition of shared health facilities.

In both our written and oral testimony, our initial reaction was that the Committee Report should indicate the definition is intended to apply to providers in situations where there is evidence of wrongdoing.

We have again concluded that this is the only feasible approach. We considered language changes to Section 1125, particularly in paragraphs (3)(A) and/or (B) or additional language in the section on exceptions. Further, we considered an option of increasing the dollar limits in paragraph (3)(B). We were unable to better define a "shared health facility" to assure that it only encompasses the potentially fraudulent and abusive provider and safeguards the legitimate entities from unnecessary administrative burdens or misleading publicity.

We do suggest that the following word changes be considered:

In Section 1125 (3)(A), after the phrase "such practitioners have a person" in line 17 of the bill and again in line 23 after the phrase "or a person", add the phrase "including a practitioner who is also furnishing health care."

This language would close an apparent loophole whereby a practitioner could limit his income to fall under the guidelines in Section 1125 (3)(B) and "manage" the facility and services for the other practitioners.

As a final comment, it appears the key to assuring the intent is met is going to have to be the way it is enforced. We would recommend that Congress closely monitor the implementation of this bill and obtain an annual report on associated activities. Such follow-up may be the most effective way of determining the needed refinements, if any.

Mr. ROGERS. Thank you. We are grateful for your presence here today.

Next we have a joint presentation by Group Health Association of America, Jeffrey Cohelan, executive director, and our distinguished former colleague and the Kaiser Foundation Health Plan, Gibson Kingren, consultant and also accompanying them is Harold Frank Newman.

Your statements will be made a part of the record.

STATEMENTS OF JEFFERY COHELAN, EXECUTIVE DIRECTOR, AND HAROLD FRANK NEWMAN, M.D., VICE PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA, INC., ACCOMPANIED BY GIBSON KINGREN, KAISER FOUNDATION HEALTH PLAN

Mr. COHELAN. I am Jeffery Cohelan, executive director of the Group Health Association of America, Inc. I am accompanied by the distinguished physician, Dr. Harold Frank Newman, former chairman of the board of Group Health Association of America, and currently vice president of the Kaiser Foundation Health Plan and by Mr. Gibson Kingren of the Kaiser Foundation Health Plan.

Group Health Association of America, Inc., is the trade association of the major prepaid group practice plans in the United States. As this committee is well aware, the prepaid group practices were the predominant organizations used as a basis for the enactment of the Health Maintenance Organization Act of 1973. While not all of our member plans have qualified under that act they are more frequently than not referred to as HMO's, or health maintenance organizations.

Our 72 member plans represent a proven system of efficient health care delivery. HMO's are generally acknowledged more economically than the medical care community at large. This is attributed in large part to their operation on a prepaid basis at fixed premiums, which gives these plans incentives to keep costs low and to control utilization. At the same time, these plans have demonstrated that quality of care need not be sacrificed in order to achieve cost containment. Moreover, our prepaid group practice plans have shown that the twin goals of cost containment and high quality care can be achieved without abusing either the consumer or the consumer's pocketbook.

It is in this context that we congratulate the committee for considering H.R. 3, the medicare and medicaid antifraud and abuse amendments. Legislation of this type has long been needed and we support your efforts. However, we would like to take this opportunity to urge you to consider additional amendments which I will describe in any following remarks. These amendments would enable HMO's and direct service prepaid systems to provide services to medicare and medicaid beneficiaries on the same basis that they provide services to their other subscribers. In this way the medicare and medicaid programs would reap the full benefits of the cost-saving measures inherent in HMO operations. Fraud and abuse in the medicare and medicaid programs are inexcusable and abominable. Needless surgery and assembly line medicine, exorbitant overcharges and subpar services—the litany of abuse is unending. The measures you are considering while clearly not a panacea, will go a long way toward improving the intolerable situation that exists, not only in these federally funded programs, but in the Nation's health care system as a whole.

This legislation by itself cannot and will not curb the fraud and abuse so prevalent in the medicare and medicaid programs. However, we believe it will focus the Nation's attention on possible remedies. A major thrust of this legislation, the PSRO amendments in particular, is cost containment. The HMO accomplishes this sought-after result through a system of fixed prepayment on a capitation basis. This system obligates the HMO to render comprehensive care on a risk basis. With risk, and through varied arrangements with the providers of care, the HMO has a natural incentive to operate economically and efficiently without sacrificing high quality care. Failure in either of these regards will: One, financially overburden the HMO or two, lead to a loss of enrollees, or both.

For too long, HMO's have been forced, to the disadvantage of their members, to participate in medicare and medicaid under rules designed for fee-for-service providers. It is time that these organizations be given the opportunity to provide services and receive payment for them in a manner that emphasizes their basic strengths. It is ironic that neither the medicare nor the medicaid programs fully recognize and take advantage of these inherent HMO principles.

We are entirely sympathetic with the committee's desire to prevent the abuse and the alleged fraud practiced by unscrupulous providers and entrepreneurs in all regions of the country. These cases have been the subject of several investigations by the Congress, the General Accounting Office, and State and local agencies. More to the point, however, we at GHAA are concerned that such unscrupulous operations not be confused with the legitimate and conscientious prepaid group practice plans which comprise our memberships. Confusion based on unfounded allegations does a great disservice to the HMO movement.

This organization, GHAA, has continuously striven to assure that the group-practice prepayment plans which serve the health care consumers of this country will be reputable, well financed, and highly conscientious operations. We have continuously sought funding of the Federal HMO demonstration project at a level which would permit adequate oversight and evaluation of funded projects. Most recently we strongly urged the inclusion of a modest increase in the 1977 supplemental and fiscal 1978 budgets to permit greater oversight of HMO activities. Our zealousness in these endeavors is backed by a conviction that HMO's, properly structured, can efficiently and economically offer the broadest benefits of the highest quality to consumers in every socioeconomic category.

Congress has established a national policy of encouraging the development and growth of HMO's in order to make them available to persons throughout the country. Even where HMO's exist, however, they may not be available to medicare and medicaid beneficiaries. Existing laws and regulations do not provide appropriate incentives to encourage vigorous HMO involvement in these programs.

HMO's which enter into a risk basis contract to provide services to medicare eligibles must assume all the risk of providing care to these beneficiaries. However, they are deprived of the savings from their efficiencies by a requirement that such savings must be shared equally with medicare. HMO's are understandably reluctant to enter such contracts.

The medicaid program similarly lacks incentives to encourage HMO involvement. The States administering the program are not required to undertake good faith efforts to enter into prepaid contracts with HMO's. Nor are States prohibited from imposing additional or conflicting requirement for participation on qualified HMO's which have satisfied the stringent requirements of the HMO Act of 1973.

Moreover, since Congress has established a national policy of encouraging the development and growth of HMO's, we would propose two amendments to the legislation under consideration.

First: One of the means of accomplishing the goals of the national HMO policy is the requirement in the HMO Act that most employers must offer qualified HMO's to their employees. We believe that offering qualified HMO's to beneficiaries of medicaid programs whenever such an HMO is available would be consistent with and further that national policy. Arrangements for such care would be subject to standards assuring fraud and abuse prevention.

Second: HMO's and direct service prepaid systems which serve the poor either exclusively or as the predominant part of their business should be permitted to enter into prepaid contracts with the States. Under the present rules, such organizations require special authorization. We are willing to sit down with the committee or its staff to work out standards designed to prevent fraud and abuse and, at the same time, permit such plans to offer health care services on a prepaid risk basis to eligibles.

Our strongest probability of achieving appropriate health delivery with inflationary and cost restraints is to build a system with appropriate incentives. We should concentrate on building competitive health delivery systems of which an HMO is one—and only one. We need a law which not only permits experimentation but which actually encourages the development of new and better ways of organizing, delivering and paying for health services. A large part of our problem today is that we have frozen into law a single monolithic form of payment and delivery of health care with almost no opportunity to develop systems.

Passage of the HMO Act in 1973 amounted to a congressional ratification of the successful operation of prepaid direct delivery health care systems where and when they have been tried. Indeed, most of the sponsors of the various national health insurance proposals have included the HMO alternative in their proposals. We believe this to be an expression of confidence in our system and its worth as part of health care delivery in the United States. We ask that the medicare and medicaid programs share that confidence. An equitable reimbursement and sound HMO management with appropriate Federal oversight will guarantee satisfactory results. We hope that the committee will see fit to use the HMO strategy to advantage in combating the problem of fraud and abuse in the national health care arena.

Mr. Chairman, my colleague, Dr. Newman, would like to further comment in respect to the cost accounting testimony that was rendered by Congressman Moss earlier this morning.

Mr. ROSTENKOWSKI [presiding]. You may proceed, Doctor.

Dr. NEWMAN. Thank you, Mr. Chairman.

A considerable amount of interest has been expressed this morning in uniform reporting and accounting requirements as advocated in Congressman Moss' testimony regarding H.R. 4211. Congressman Moss did state such reporting requirements must be adapted to the situation being audited; and I would like to elaborate on the importance of such adaptation in present group practice HMO's holding risk contracts with State government. A prepaid group practice HMO with such a contract has already fixed the amount to be paid in its guaranteed rate or monthly premium. The premium is based on the HMO's prospectively determined budget for providing care to the enrollees in the HMO; if reporting and accounting requirements are enacted, they must be geared to the unique characteristics of the HMO's operation and not on fee-for-service operations.

To force prepaid group practice HMO's into a fee-for-service accounting and statistical mold would result in comparing apples with oranges, and inferences resulting from that data would be misleading and false. I would hope any such requirements will recognize the unique nature of the HMO and build on good accounting and reporting systems already in place and not impose burdensome changes largely unrelated to the HMO's basic operation.

In closing, I would like to emphasize that I am not advocating we be exempted from providing meaningful costs and utilization data. I am only requesting that the costs and data be relevant; and we would be happy to cooperate with staff in developing such reports.

Thank you.

Mr. Rostenkowski. Thank you, Doctor.

Mr. Cohelan. Mr. Chairman, we would be pleased to answer any questions.

Mr. Rostenkowski. Thank you very much. Thank you for your presentation.

Dr. Beddingfield?

STATEMENT OF EDGAR T. BEDDINGFIELD, JR., M.D., CHAIRMAN, AMERICAN MEDICAL ASSOCIATION'S COUNCIL ON LEGISLATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, LEGISLATIVE DEPARTMENT, AND DAN HILL, ASSISTANT DIRECTOR

Dr. Beddingfield. Thank you.

Mr. Rostenkowski. Welcome to the committee, Doctor.

Dr. Beddingfield. Thank you, Mr. Chairman.

Mr. Chairman, I am Edgar T. Beddingfield, M.D., a practicing physician in Wilson, N.C. I also serve as chairman of the American Medical Association's council on legislation. With me today is Harry N. Peterson, director of AMA's legislative department; and on his right, Mr. Dan Hill, the assistant director.

We are pleased to have this opportunity to present the views of the American Medical Association on H.R. 3, the medicare-medicaid antifraud and abuse amendments.

We share with Congress a desire to see the development of appropriate legislation that will identify and control fraudulent activities that may exist in the medicare, medicaid, and maternal and child health programs. The American Medical Association deplores fraud in any governmental health program and believes that steps must be taken to insure the integrity of all these programs.

Recent activities that have come to light in connection with the medicaid mills are offensive to any person, but especially so to the medical profession.

H.R. 3 has frequently been characterized as a bill aimed at the medicaid mill and is intended, as stated by its sponsors, to reduce the problems of fraud and abuse in medicaid and medicare programs.

Although this legislation may be aimed at the medicaid mill, it has far exceeded that mark. This bill would subject virtually all group practices in the United States to the same requirements as it does the so-called medicaid mills. The various provisions of H.R. 3 are so sweeping in their scope that their effect is not simply an attempt to control medicaid mills, but rather a blanket authorization to investigate the actions of almost every practicing physician in the country.

This bill, in its enthusiasm to reach the fraudulent activities of a few, subjects all physicians to its provisions. While we support in principle the objectives of the bill, to combat and eliminate fraud, because of its broad scope H.R. 3 should not be adopted without substantial amendment.

In our full statement submitted to you today—which we request be incorporated into the record, we discuss in detail some of the underlying causes of fraud, the problem areas of this bill, as well as those provisions which, in our view, are commendable together with suggestions for appropriate modifications. We urge you to consider our statement carefully as you consider this legislation.

In the time allotted for oral presentation today we will limit our comments to a few of the particularly troublesome aspects of this legislation—the impact of disclosure requirements, the unnecessarily broad scope of the bill, and the undesirable changes proposed in functions of the PSRO.

Before I go into these specifics, there is an additional point that should be stressed. There are already Federal and State laws to control fraudulent activities in governmental programs. These statutes should be conscientiously and rigorously enforced. All too often, the enforcement record has been unsatisfactory because the investigators and prosecutors are under-financed and understaffed. Sufficient funding and technical support should be provided for these enforcement agencies. Many of the problems in medicare and medicaid that we are discussing today would be diminished if more effective enforcement occurred.

H.R. 3 would require disclosure of certain financial and ownership information by providers and suppliers, including shared health facilities. These terms are so broadly defined that, instead of concentrating on those few who may in fact be violating the law, all but the solo practitioner would be covered.

These disclosure requirements raise several questions. What uses are to be made of this material? Indeed, what agency presently has the manpower and financial resources to sift through all the data? We point out that the law enforcement agencies of the Federal Government and the States apparently cannot at the present time speedily investigate and prosecute violations of existing laws.

Does the mere ownership of, or participation in, a group health facility imply any kind of criminal activity? Should the amount of income connote impropriety? Group medical practices legitimately take on a variety of forms. No single kind of arrangement is inherently fraudulent. Fraud is the work of people, not structures.

Finally, is it at all likely that a person engaged in fraudulent activity would report information establishing grounds for prosecution or dismissal from the program? On the contrary, on paper, even the medicaid mill might look good.

While the bill would seemingly restrict applicability of the disclosure requirements by limiting disclosure to only those instances in which the Secretary or Comptroller General makes a request specifically addressed to that entity, this restriction is ephemeral at best. If the purpose of disclosure is the collection of data that would either identify the existence of a medicaid mill or the perpetuation of a fraud, then on what bases would the respondents be chosen? It would appear that the only choice would be to require all covered entities to respond.

We believe that this provision is overly broad and should be restricted.

We have serious reservations about the definition of a shared health facility. This definition is so broad that virtually every legitimate group practice could be included within its ambit, and then be subject to those provisions of the bill designed to increase surveillance over medicaid mills.

The financial aspects of this term are also troublesome. For a variety of reasons, primarily connected with the vagaries of the Federal reimbursement programs, a group practice could find itself covered by the definition where only one of its members reaches a certain financial plateau. This could happen when a physician receives over $5,000 reimbursement in a month or $40,000 during the course of a year. The physician could readily fall into such a category by nature of circumstances—payment schedules of carriers, submission of claims, et cetera—over which he may have no control. Payments during one month could represent services provided over an extended period. This does, in fact, happen.

Administratively such a provision could be troublesome. Does the fact that one member of a group practice has been reimbursed over $5,000 in any 1 month mean that all members of the group are thus subject to the disclosure provisions for just that month? Or for that year? What happens if a practitioner in the group reaches the financial plateau only once? Is the group then forever covered by the disclosure provisions of the bill? We believe that, as a minimum, the income portions of the definition of a shared health facility should be deleted.

On the other hand, another feature of the bill is unclear. We question how the bill specifically addresses the problem of reaching the entrepreneur—the one, often a nonphysician—who behind the scene is responsible for putting together the medicaid mill. It is the entrepreneur's desire for profit that leads to the creation of many medicaid mills, and it is not clear to us how this bill deals with these instigators. So long as such entrepreneurs remain untouched, fraudulent practices will be encouraged.

We would also add that the definition of a supplier is so broad as to encompass shared health facilities, thus compounding the pervasive effects of the bill.

As to the PSRO amendments, H.R. 3 also contains several amendments to the PSRO law. We believe that these amendments are not essentially directed toward control of fraud, but that in any event such proposals are at this time inappropriately included in this legislation. Amendments to PSRO are needed, but they should receive separate consideration. However, since these substantive changes are proposed in H.R. 3, we will comment on them.

We are very concerned over the extent and nature of these changes which significantly alter the entire thrust of the PSRO program. As you are aware, the PSRO program has been reluctantly or even poorly received in certain areas of this country, and is only now beginning to overcome the resistance of many health care practitioners and providers. We believe that many of the proposed changes in H.R. 3 could erase the gains already made and severely retard the further development of professional review of health services.

At the present time PSRO review is limited to services furnished by or in institutions, except that an individual PSRO may request authority to expand its review to cover other health services. H.R. 3

would repeal this limitation. Thus review of every physician's office would become mandatory for qualified PSRO's.

The initiative for expanded review currently residing in the PSRO would be removed. Flexibility in responding to local needs would be eliminated. Moreover, even during the conditional period, it would be the Secretary who would designate the extent of review by a PSRO. Expansion of PSRO review could be determined by the Secretary and not be based on local conditions.

Thus, this bill affects all practicing physicians by making operational to their practices all conditions and requirements of the PSRO law.

In our view, the current limitation to review of services by or in institutions, with the initiative for expanding review residing in the PSRO, should be retained.

Also under the bill the PSRO could abstract records of any practitioner during any PSRO inspection. This provision is both unnecessary and unwise for several reasons.

First: Present provisions of the PSRO law require the physician to document adequately any claim. We believe this requirement is sufficient to provide any needed records.

Second: Such a provision enhances the risks of breaching the confidentiality of medical records. The increasing violations of the privacy of medical records are already well-documented. To allow the PSRO to rummage through a physician's files only increases the dangers. Obviously not all information in a medical record is relevant to PSRO review and should not be made available.

Third: When abstracting authority is combined with the law's authority to inspect the physician's office, and combined with other provisions of H.R. 3 mandating PSRO review of services furnished in the physicians' offices and requiring the PSRO to turn over records to a law enforcement agency, the fundamental shift in the primary function of the PSRO becomes all too clear.

The PSRO would be less of an educational and quality review mechanism and become more nearly an investigative arm of law enforcement agencies. This provision authorizing the PSRO to abstract physician records should be deleted.

As we just mentioned, the PSRO would be required to provide, either on request or at its own initiative, information relating to possible fraud to State and Federal law enforcement agencies investigating fraud in Federal health programs. This provision should not be adopted.

Under present law, the PSRO's are required to send to the statewide council any information which might indicate violations of program obligations. The statewide council is then to refer this data to the Secretary for disposition. Any action taken on prosecutions for fraud thus rests with HEW and the Justice Department or appropriate State authorities. We believe this present provision is sufficient.

We call your attention to the AMA proposed amendments to PSRO, a summary of which is attached to our full statement, and we urge your consideration of these proposals. These amendments have now been introduced as H.R. 4510.

We believe that instances of fraud must be identified and the perpetrator prosecuted. However, H.R. 3, unless significantly modified might have a much greater adverse social impact than would the problem toward which the bill is directed.

We believe that the intent of H.R. 3 is laudable, but we do recognize the adverse results which could occur if the legislation is passed as presently drafted. The scope of the bill must be narrowed so as to accomplish its avowed purpose with minimal negative effects on honest practitioners and beneficiaries. While it is imperative that we take all necessary steps to identify and to prosecute those committing fraud, we must not through our fervor lose sight of the primary goal to be served—assuring access to quality medical care. To this end, we must not needlessly impose broad regulation on all and thus discourage participation in providing patient care.

Before closing, I would like to stress again the need to supply enforcement agencies with the resources necessary to enforce existing antifraud laws. As I said earlier today, many of these problems in the medicare and medicaid programs could be diminished through rigorous enforcement of present statutes.

We would be happy to work with the subcommittees in developing a bill that would more appropriately address the problems of fraud and would have a significant impact on violations of the medicare and medicaid laws.

At this time we would be pleased to respond to any questions the subcommittees may have.

[The prepared statement follows:]

Statement of the American Medical Association

(By Edgar T. Beddingfield, Jr., M.D.)

Honorable Chairmen and Members of the Subcommittees, I am Edgar T. Beddingfield, Jr., M.D., a practicing physician in Wilson, North Carolina. I also serve as Chairman of the American Medical Association's Council on Legislation. With me today is Harry N. Peterson, Director of AMA's Legislative Department.

We are pleased to have this opportunity to present the views of the American Medical Association on H. R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments.

We share with Congress a desire to see the development of appropriate legislation that will identify and control fraudulent activities that may exist in the Medicare, Medicaid and Maternal and Child Health programs. The American Medical Association deplores fraud in any governmental health program and believes that steps must be taken to insure the integrity of all these programs.

But first before we discuss the bill we would like to address certain points.

This legislation has frequently been characterized as a bill aimed at the "Medical mill" and as such is intended to reduce the problems of "fraud and abuse in medicaid and medicare programs." Fraud and abuse have been widely publicized in recent months as occurring in the so-called "Medicaid mill."

To the extent that the legislation was aimed at the Medicaid mill it has far exceeded the mark. Since this bill has been characterized as the "Medicaid mill" fraud and abuse bill, practically all group practices could be stigmatized because of the broad application of its provisions.

Is it the "Medicaid mill" that is affected by this bill? In the broad approach use, this bill is in fact aimed at a large proportion of all practicing physicians, casting its stigma of impropriety upon the tens of thousands of physicians who fall within its purview. This bill subjects virtually all group practices in the United States to the same requirements as it does the so-called "Medicaid mill." All groups (of two or more practitioners) would be subject to the extensive disclosure of records provisions. All practicing physicians (who render Medicare and Medicaid services) would be subject to PSRO review of outpatient services.

The bill endangers the confidentiality of patient records, and certain provisions cannot be justified as needed or even as wise tools to combat fraud. When these disclosure provisions are considered along with other changes the bill would make (e.g., requiring PSRO review of all outpatient services, subjecting every physician office to inspection and authorizing the PSRO to "abstract" information from confidential patient records, authorizing PSRO at its own instance or requiring it at that of an investigating agency to turn over information to a law enforcement agency, and allowing subpoena power by the Comptroller General over *all* participants in any of the programs under Social Security, whether a provider or beneficiary), the result is not simply an attempt to control "Medicaid mills" but rather authorization to investigate the actions of almost every practicing physician in the country.

This bill in its enthusiasm to reach the fraudulent activities of a few blankets in all physicians. H.R. 3 should not be adopted without substantial amendment.

I. GENERAL MEDICAID/MEDICARE ISSUES

Earlier Congressional investigations into fraud in federal health programs have established that only a small minority of physicians have engaged in practices that could be considered fraudulent. The AMA urges that this minority be brought to justice. However, justice is not served if all practitioners are subjected to harassment and restraint so that a few malefactors may be apprehended. I am sure the Committee's goal is that any corrective legislation be fashioned to accomplish its purpose without inflicting punitive measures upon the vast majority of honest physicians who are dedicated to serving their patients.

In considering any legislative response to the problems of fraud in Medicare and Medicaid, the Congress should also determine and respond to the causes of the problems. It will indeed be a losing, never ending battle if the root causes for fraudulent activity remains unaffected.

Let us examine for a moment some of the causes of fraudulent activity under Medicare and Medicaid. It is true that physicians, although only a relatively few, have engaged in fraudulent activities in these health programs. This is regrettable, but it is a fact of life that among any group of individuals some will be found who break the law.

It should be remembered that offenders in the Medicare and Medicaid programs are not limited to physicians, but may be found among all practitioners and providers. However, in the case of physicians, not only does the fraudulent physician incur the condemnation of society in general but also the condemnation of his professional peers.

Some of the fraud and abuse has been laid to the factoring of claims. Would the system of factoring exist to any significant extent if the government paid claims for health services with any kind of rapidity—or even with ordinary business dispatch? We think not. A reimbursement system that paid fairly and promptly would in large measure eliminate the need for factoring arrangements.

In some instances, there have been reports of administrative ineptitude, particularly in Medicaid, so pervasive as to invite illegal activities.

A further source of difficulty is the fact that those currently charged with investigating fraud and those who prosecute illegal activity are understaffed or for some other reason ineffective. We already have on the books many laws which prohibit and make illegal the kinds of activity that H.R. 3 seeks to stop, yet they are too often enforced only spasmodically.

This poor administration and enforcement record only encourages those few who would "rip off" the system into believing that they can get away with their deeds.

We believe that the sources of the problem are multi-faceted and complex. A variety of approaches to solving the problem is needed.

To this end, the AMA has become involved in playing a role in urging awareness of and combating fraud.

II. AMA ACTIVITIES

While we believe H.R. 3 should not be supported as written because of its unnecessarily broad impact, we do strongly support proper activities in both federal and state arenas to weed out these few individuals who engage in fraud.

For example, we have recognized the need for certain reforms in Medicaid and Medicare programs—perhaps directed toward and intended to encourage greater participation by physicians in this program. We also believe that certain administrative reforms are urgently needed and could serve as disincentives to fraud.

The medical profession through its respective professional societies has frequently stated its desire to cooperate with state and federal authorities in ending any fraudulent activities.

In July 1976 and again in December of 1976 the AMA House of Delegates adopted the following policy:

"The American Medical Association condemns and deplores all acts of fraud and wrongdoing, including in particular any wrongful acts as recently reported in the Medicaid and Medicare programs. We urge that responsible government agencies proceed with all due speed in the prosecution under the provisions of due legal process of all who are charged with fraudulent misconduct. We will continue to offer our cooperation and assistance in bringing to an end such activities."

At the same July session the House of Delegates approved two model state bills prepared by our Association which would strengthen the disciplinary procedures and powers of state licensing and regulating bodies. This would in fact allow greater physician monitoring of the actions of other physicians and would allow greater flexibility in controlling any physician engaging in fraud.

In addition, the AMA supported in principle legislation in the 94th Congress which was directed toward control of fraud in the Medicare, Medicaid, and Maternal and Child Health Programs under the Social Security Act. While that legislation was overly broad in certain aspects, the AMA offered assistance to the Committee on Interstate and Foreign Commerce in its consideration of changes so that the legislation would have more nearly provided regulation of "Medicaid mills" without unnecessary provisions, such as the onerous imposition of disclosure of confidential records of all physicians.

However, the present H.R. 3 is, in comparison with the legislative proposal of last year, more pervasive in its effect.

III. OVERVIEW OF PROVISIONS OF H.R. 3

H.R. 3 can be readily separable into three distinct parts. The first part pertains generally to provisions directed toward disclosure of records by certain entities. The recond part pertains to fundamental changes in the PSRO law. The third part pertains to amendments to the Medicaid/Medicare law and includes provisions for increasing the penalties for fraud, for suspension of a practitioner, and for other miscellaneous amendments.

The disclosure provisions would require reporting a variety of information by a "provider" or a "supplier" of items or services reimbursable under titles V, XVIII, or XIX, or by a Medicaid or Medicare carrier or intermediary. Information to be supplied at the request of the Secretary of HEW or the Comptroller General would consist of the identity of any person having a 5% interest in the entity, of all officers, directors, or partners, of any business transactions between the entity and any officer, director, partner or 5% owner, and of a report of costs and charges for items reimbursed under titles V, XVIII or XIX. Access to books and records of any independent pharmacy, or supplier of durable medical equipment, or of a renal disease facility would be required. Failure to supply requested information would result in disallowance of participation in titles V, XVIII or XIX.

There would also be added new definitions—including those for a "shared health facility" and a "supplier."

A "shared health facility" would be defined as "any arrangement whereby—

(1) Two or more health care practitioners (one or more of whom receives payment on a fee-for-service basis under title V, XVIII or XIX. . .) practice their professions at a common physical location;

(2) Such practitioners share (A) common waiting areas, examining rooms, treatment rooms, or other space, (B) the services of supporting staff, or (C) equipment, and

(3) (A) Such practitioners have a person who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by the practitioners to their patients, or a person who makes available to such practitioners the services of supporting staff who are not employees of such practitioners, and either such person is compensated in whole or in part, for the use of such physical location or support services pertaining thereto, on a basis related to amounts charged or collected for the services rendered or ordered at such location, or

(B) At least one of such practitioners received payments on a fee-for-service basis under titles V, XVIII, and XIX . . . in excess of $5,000 for any one month during the preceding 12 months, or in an aggregate amount exceeding $40,000 during the preceding 12 months;

Except that such term does not include a provider of services (as defined in section 1861(u)), a health maintenance organization, a hospital cooperative shared services organization . . . , or any public entity."

A "supplier" would include any individual (other than an individual practitioner), organization, or entity furnishing items or services reimbursable under titles V, XVIII, or XIX.

In addition, The Social Security Act would be amended to require reporting by a facility of any person having a 5% ownership in the facility who had been convicted of fraud under Medicaid, Medicare or Maternal and Child Health. This reporting would also be applicable to any person convicted during any time prior to enactment of the provision as determined by the Secretary. The bill also gives the Comptroller General broad subpoena powers relating to all programs under the Social Security Act. Under this provision he would subpoena records of any person, whether a beneficiary, a practitioner or a facility.

The bill also would establish several new PSRO amendments. Some of those amendments—those that would eliminate much of the duplicative review of services by different reviewing entities and those that would make PSRO determinations final in many cases—would be beneficial, and we support them. However, the bill also would significantly amend the law by making mandatory the review of all outpatient services by a qualified PSRO and requiring as a condition to full designation of a PSRO that a plan be developed under which all health services (including outpatient services) under titles V, XVIII or XIX be reviewed.

In addition, PSRO's would also be able to abstract the records of practitioners who are subject to PSRO review. Moreover, the PSRO would be authorized to turn over any information to a law enforcement agency at the request of the agency or on its own. Other PSRO amendments are discussed later.

The Medicare and Medicaid amendments would allow practitioners to be suspended from the program upon conviction of fraud whether the conviction occurred prior to or subsequent to enactment.

In addition, penalties for fraud under the program would be raised in magnitude (i.e. the offenses would become felonies).

Other changes would be made including a general prohibition against assignments of a claim by a practitioner, except under specific circumstances.

There are provisions of this bill which indeed could contribute to combatting illegal activities. However, there are many other provisions which, in our view, contribute little to solving these problems. The definitions are so broadly drawn as to affect nearly all practitioners. The foreseeable result of such provisions is an avalanche of paper descending both from and upon the Federal government. Moreover, it is highly unlikely that information will be furnished by anyone of an incriminating nature.

We would now like to turn our attention to a discussion of specific portions of the bill.

IV. DISCLOSURE REQUIREMENTS

A. Disclosure

H.R. 3 would require disclosure of certain financial and ownership information by providers and suppliers, including "shared health facilities." These terms are broadly defined and all but the "sole" practitioner would be covered by these requirement. Instead of concentrating on those few who may in fact be violating the law, a very broad brush is used in the definitions.

Several important questions about these disclosure requirements exist. What uses are to be made of this material? Does the ownership of a type of health facility imply criminal activity? Is it likely that a person engaged in a fraudulent activity would report something likely to lead to his prosecution or to his being dismissed from the program?

While the bill would seemingly restrict applicability of the disclosure requirements by limiting disclosure only to those instances in which the Secretary or Comptroller General makes a request "specifically addressed to that entity," this restriction is ephemeral at best. If the purpose of the bill is to identify the Medicaid mill or fraudulent activity based on information to be disclosed, how would a determination be made as to which entity would be required to respond? It would appear that the only alternative would be to require a mass request of all covered entities.

We believe that this requirement is overly broad and should be restricted.

B. *"Shared Health Facility"*

We have serious reservations about the definition of a "shared health facility." This definition is so broad that virtually every group practice could be included within its ambit. Again, the use of a fine mesh net to catch a few could, in the process, enmesh almost all group practices.

For example, the definition states that such a facility is one in which two or more physicians share areas and at least one receives, on fee-for-service, \$5,000 in one month or \$40,000 during a year from Medicare, Medicaid, and Maternal and Child Health. This definition, purportedly intended to cover "Medicaid mills," would in fact cover many group practices (even those where there would be no financial arrangements concerning their practice). Group practices can share a common, physical location; they can share waiting rooms or other facilities. The individuals can receive fee-for-service. At least one individual can receive \$5,000 in one month (or \$40,000 in a year) from the programs. It must be remembered that the amounts cited in the bill are "gross" amounts and do not take into consideration costs of practice.

Furthermore, for a variety of reasons over which the physician has no control, he may easily come under the financial criteria for a particular period.

Because of the potentially broad inclusion of many group practices in the definition of "shared health facility" through the income criteria, we believe that this portion of the definition should be deleted. We also point out that the entire definition is rendered superfluous by the breadth of the term "supplier." As defined, "supplier" already encompasses all forms of group practice, including "shared health facilities."

V. PSRO AMENDMENTS

H.R. also contains several amendments to the PSRO law. We believe that these amendments are not essentially directed toward control of fraud, and such proposals are inappropriately included in this legislation. We also believe that the proposed changes in the PSRO law will exacerbate the resistance to the PSRO program that already exists in many areas. The PSRO program under existing law establishes a mechanism for review by physicians of services provided with respect to the appropriateness, the quality, and the propriety of the location where they were provided. PSRO was to serve primarily as an educational process to assure quality. Under the bill, however, significant changes of far-reaching implication would be made through legislation directed toward control of fraud as perpetrated by "Medicaid mills."

As we have pointed out above, the "fraud" provisions of the bill are potentially applicable to all group practices. The PSRO amendments, in turn, would affect every physician having patients who are beneficiaries of federal programs.

We believe that amendments to the PSRO program are needed, and we have developed our own recommendations for amendment. We also believe that full consideration of the amendments as proposed in H.R. 3 should be in separate legislation and considered separately.

However, since H.R. 3 does present substantive changes to PSRO we will comment on those changes.

In addition, we call attention to Appendix A attached to this testimony, which sets out a listing of AMA's suggested amendments to PSRO, and we urge your consideration of these proposals. We are pleased to note that certain of the PSRO amendments in H.R. 3 are similar to those in our bill, which has been before the Congress during several sessions.

A. Mandatory Outpatient Review

At the present time PSRO review is limited to services furnished by or in institutions, except that the individual PSRO may request authority to expand its review to other services. Under the bill this limitation would be repealed. Thus review of every physician's office would be mandatory by qualified PSRO's. The initiative for expanded review currently in the PSRO would be removed. Flexibility in meeting local needs would be eliminated. Moreover, even during the conditional period it would appear the Secretary would be the one to designate the extent of review by any PSRO.

Thus this bill affects all practicing physicians by making operational to their office practices all conditions and requirements of the PSRO law.

In our view the repeal provision is undesirable. It would jeopardize the development and current acceptance of the PSRO program. The present provisions of Section 1155(g), limiting review to services furnished by or in an institution (with initiative in the PSRO for expanding review to other services) should be retained. The proposed authority to request review of the shared health facility on a priority basis would be appropriate if the term "shared health facilty" were properly defined.

B. Abstracting Records

Under the bill the PSRO could abstract records of any practitioner subject to review.

This provision is both unnecessary and unwise for several reasons.

First, present provisions of the PSRO law require the physician to document adequately any claim. We believe this requirement is sufficient to provide any needed records.

Second, such a provision as proposed by H.R. 3 would subject the physician's records to a breach of confidentiality by allowing the PSRO to "rummage" through records. Obviously not all information in a medical record is relevant to PSRO review. Yet, an unavoidable corrollary to "abstracting" information from a record is physical access to the record and thus access to confidential information.

Third, when the new abstracting authority is considered along with present provisions of the law allowing inspection of the office and combined with other proposed provisions of H.R. 3 mandating PSRO review of all outpatient services (including physician's offices), requiring the PSRO to turn over records to a law enforcement agency, and requiring disclosure of certain information, the fundamental shift in the primary function of the PSRO becomes all too clear.

The PSRO would become less of an educational and quality review mechanism and more nearly an arm of enforcement agencies. This provision should be deleted.

C. Disclosure of Information by PSRO

The obligation of a PSRO to disclose information would be expanded by provisions of this bill. PSRO's would be required to provide, either on request or at its own initiative, to state and federal agencies responsible for investigating fraud and abuse, any information that would assist the agency. The thrust of this amendment is to make the PSRO an investigation arm of law enforcement agencies. Such a change is objectionable because it is, in our view, a perversion of the original intent of the PSRO program. We are concerned that such a requirement could hamper the development of PSRO's. Is it realistic to expect a citizen voluntarily to place himself in a position where confidential information can be involuntarily taken from him for the purpose of using such information against him? This new reporting provision is unnecessary and undesirable.

PSRO's are quired under the present law to send to the statewide council, which would forward to the Secretary, any information they have which might indicate violations of program obligations. We believe that this provision is sufficient for purposes of reporting program violations. Any action taken then on prosecution for fraud would properly rest with HEW and the Justice Department.

The provisions authorizing and requiring the PSRO to turn information over to law enforcement agencies should be deleted.

D. Finality of Review

A further amendment would allow the PSRO determination of medical necessity, quality and appropriateness to be final, and not be reviewable for purposes of payment, by Medicare intermediaries or carriers, or State fiscal agents. We support this provision making the PSRO determination final, but believe this should not be limited to purposes of payment. Moreover, since the bill lists those review mechanisms which would be superseded by PSRO review, program review teams should also be specifically included so that PSRO determinations would have wider applicability and be governing for all program purposes with respect to medical necessity, quality and appropriateness. This amendment is much like one of AMA's.

E. Duplication of Review

Another salutary amendment deals with the problem of duplication of review. We are encouraged that the bill recognizes the need for the PSRO to be the sole body to review for purposes of determining quality, necessity, and appropriateness of care. However, the bill states that duplication of review will be avoided only "to the extent specified by the Secretary." We believe that this limitation should be deleted. Duplication of review should not exist at all, and the PSRO should be the review body. A power left to the discretion of the Secretary only serves to muddle the issue. The decision to stop duplicative review should be clearcut, when the requisite finding has been made of the PSRO's competency. Such a change would more nearly reflect the AMA proposal.

F. Extension of Conditional Approval Period

The PSRO program has experienced difficulties in implementation. We support the provision in H.R. 3 extending the period of conditional status for an additional twenty-four months.

However, as we stated above, we believe that the PSRO should not be required to review all medical services (including outpatient services) as a condition for becoming fully designated.

G. Other PSRO Amendments

Additional provisions should be mentioned.

One would provide payment to a PSRO or its members or employees for expenses incurred in defending any suit brought in connection with PSRO activities. We support this provision, but recommend that it be expanded to include costs involved with any claim, and also provide payment for any judgment recovered. As so modified this would be much like one of AMA's.

Another provision would liberalize eligibility by a physician for review of services in an institution by removing the current strict limitation with respect to financial interest in the institution. The new provision would not prohibit review unless the physician had a "significant financial interest." This amendment also is similar to one proposed by AMA.

A further amendment would allow the Secretary to initiate data collection systems. We believe these provisions to be beneficial in the development of the program.

VI. MEDICARE/MEDICAID AMENDMENTS

A. Penalties

The penalties for conviction of violations of the Medicare and Medicaid laws have been strengthened and most violations thereof would be felonies. The AMA has encouraged prosecution of violators of the law, and we support the provisions beefing up the penalties.

B. Suspension of Practitioners

Suspension of practitioners who have been convicted of fraud involving federal programs is also provided in the bill. We believe that suspension from the programs is an appropriate action by the Secretary or state, and we support the clarification of their powers in this regard. However, we do not understand why the suspension is limited only to physicians and other individual practitioners. Clearly physicians and other individual practitioners are not the only recipients of reimbursement under Medicare and Medicaid and certainly not the only possible perpetrators of fraud.

We believe that the suspension upon conviction should apply to all who are convicted of crimes involving fraud in these programs.

C. Assignment of Physician's Claims

Another section of H.R. 3 is intended to prevent most assignments of Medicare and Medicaid claims by physicians. As written we think the provision will do this. However, because of the potential for varying interpretations, the provision may actually interfere with physician-attorney relationships in dealing with physician accounts.

D. New Subpoena Power in Comptroller General

The bill grants to the Comptroller General the power to issue subpoenas "to any person" in connection with any "audit, investigation, examination, analysis, review, evaluation, or other function" authorized by law with respect to "any program" under the Social Security Act. The subpoenas could demand "any pertinent books, records, documents or other information."

This authority would be extremely broad, covering not only providers, practitioners, other participants, and beneficiaries of all programs (Medicare, Medicaid, Maternal and Child Health, OASDI, Supplemental Security Income (SSI), PSRO, and others) but could be directed as well to any person whether or not involved in any of the programs under the Social Security Act.

This broad proposal should be studied carefully and not swept into legislation aimed at the "Medicaid mill." The Office of Inspector General has just been established with respect to Medicare and Medicaid. That Office has been granted subpoena powers as it proceeds in its program to investigate fraud and abuse. At a time when all people are concerned with increasing government encroachment, another layer of potential harassment should not be added. We believe that the duplicative powers in the Comptroller General are unnecessary and should be deleted.

VII. CONCLUSION

In conclusion I would like to reiterate the AMA's views toward combating fraud. We deplore any activity which is fraudulent, and we support efforts directed toward identifying the fraudulent, prosecuting the fraudulent to the full extent of the law, and jailing those convicted.

We all recognize that the fraudulent activities of a few can adversely reflect upon everyone. Therefore, we urge legislative action, on both the state and federal levels, to develop proper mechanisms to deal with fraud.

The imposition of unnecessary and onerous requirements would, however, create further disincentives for provider and practitioner participation in the Medicare and Medicaid programs. This will further diminish care available to program beneficiaries.

While we support in principle the objectives of H.R. 3, the bill is nevertheless too broad and should be modified in accordance with our suggestions discussed above.

In addition, we offer the following suggestions for your consideration as you decide the best ways to combat the problems of fraud.

First, it must be recognized that fraudulent activities can be prosecuted under existing laws which should be rigorously enforced.

Second, adequate provision should be made to fund and staff the federal and state agencies responsible for investigation and prosecution of violations. Included in this would be financial and technical assistance to the programs to help them establish proper data processing controls that will identify attempted double billing, billing of services never given and other forms of fraud.

Third, the administrative policies of the government must be changed so that claims nuder Medicare and Medicaid are promptly handled. This would eliminate many of the conditions in these programs that foster unwholesome practices.

In weighing the effect on fraud and abuse, it is equally necessary to consider overall effects on program participants. Punitive measures should not subject innocent parties to unnecessary restraints and requirements. It is our concern the great number of individuals subjected to the provisions of this anti-fraud and abuse legislation far exceeds the small number of practitioners who should be the object of legislation. The significant and fundamental changes in the PSRO law, for instance, affecting all practicing physicians, should not be swept in under the irresistibel Siren's call: "Anti-fraud and abuse."

We would be happy to work with the committees in developing legislation that would more appropriately address the problems and have a significant impact on violations of the Medicare and Medicaid laws.

At this time, we would be pleased to respond to any questions the Subcommittees may have.

APPENDIX A

PSRO AMENDMENTS[1]

The following reflects the substance of AMA developed amendments to PSRO.

(1) The definition of "qualified organization" under Section 1152(b)(1) should be expanded so that organizations, including foundations, designated by medical societies will be specifically eligible for consideration as a PSRO.

(2)(A) The prohibition for the Secretary to enter into PSRO contracts with groups other than professional associations, as provided in Section 1152(c)(1), should be postponed from January 1, 1978, to January 1, 1979. The Secretary should not enter into agreement with groups other than professional associations without concurrence of the National Professional Standards Review Council.

(B) The National Professional Standards Review Council should conduct a study to review the extent of professional participation in the implementation of the PSRO program. Such study would be completed by July 1, 1978, and thereupon presented to Congress, at which time Congress could determine whether, and under what conditions, other agencies would be allowed to serve as PSROs.

(3) In order to avoid duplication, Section 1152(e) should be amended to require the Secretary to waive any or all review or similar activities under any such provision (other than PSRO) of the Social Security Act where the PSRO has been found to be performing review activities effectively.

(4)(A) Section 1156 should be amended to direct specifically the respective PSROs to ascertain and develop appropriate guidelines, (referring to norms, criteria, and standards) drawing upon the expertise of national, state, and county medical associations and specialty societies.

(B) The law should be amended to state specifically that such guidelines (referring to norms, criteria and standards) are to guides only and cannot be substituted for individual professional judgment.

(C) Section 1155(a) should also clearly include the role of the local PSRO in defining areas pertaining to necessity, quality or appropriateness.

(5) Consistent with policy in opposition to preadmission certification of institutional care, such authority presently existing in the PSRO law (Sections 1155(a)(2), (3); 1155(b)(2) should be deleted.

(6) "Regular Review" of Patient and Provider profiles should not be required to be based upon case-by-case analysis of care provided or received. Section 1155(a)(4) should be amended to allow for the review on a sample basis. In addition, confidentiality should be maintained for both patient and physician.

(7) Section 1155(a)(6)(B) should be amended to allow a physician to participate in PSRO review in a facility unless he has a "substantial" interest in the facility for which the review is performed rather than prohibiting such participation if he has "any" interest.

(8) An opportunity for physician "polling" on any designation agreement or renewal of an agreement between the Secretary and a PSRO should be afforded when specific percentages of physicians in an area desire a poll. (Section 1152(f)).

(9) Section 1160(b)(3) providing for financial penalties in lieu of termination or suspension should be repealed. A system of graduated sanctions should be established.

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[1] Amendments sponsored by American Medical Association to section 249F of Public Law 92-604.

(10) Certain reporting provisions require PSROs to submit to the Statewide Council, for forwarding to the Secretary, all determinations made by the PSRO that a practitioner or a provider has violated any obligation relating to necessity quality or situs of care furnished (Sections 1157 and 1160(b)(1)). The provisions should be amended to require the PSRO to report to the Statewide Council only when it determines that a pattern of practice requires such attention or that a provider or practitioner has grossly and flagrantly violated the obligations imposed under the Act. Such determinations should be made only after a conference with the provider or practitioner in an attempt to seek compliance, and a finding that he or it has shown an inability or lack of desire or intention to comply with the program requirements.

(11) Section 1157 should be amended to "require" the Secretary to utilize a PSRO in lieu of a program review team for certain reviews.

(12) Section 1166 should be amended to provide that the written records of Professional Standards Review Organizations, Statewide Professional Standards Review Councils, and the National Professional Standards Review Council shall not be subject to subpoena or discovery proceedings in any civil action; nor shall the identity of any member, employee, or person providing information, counsel or services be subject to subpoena or discovery proceedings; nor shall the discussion or deliberations of any organization, council member, employee, or person be subject to subpoena or discovery proceedings in any civil action.

(13) Section 1167(c) should be repealed. That provision purports to limit the liability of an individual furnishing items or services when such indivdual has acted in compliance with the norms of care applied by a PSRO, provided that he exercised due care in his conduct. This provision could have the unintended and undesirable effect of pressuring practitioners to adhere to the norms. Moreover, the provision is at best meaningless because on its face it is applicable only when the practitioner has exercised due care—the very issue at the heart of the malpractice issues.

(14) Section 1156 of the law should be amended to state the limited functions of the "norms, criteria, and standards" developed thereunder and to define their applicability in civil cases.

(15) Section 1168, referring to the reimbursement of PSRO expenses, should be amplified so that contract applicants will have an accurate understanding as to which organizational expenses will be reimbursable and should include costs, expenses, and damages incurred in connection with civil suits, claims or settlements.

(16) Section 1159(b) should be amended to allow a provider or practitioner the right of administrative hearing and judicial review on adverse determinations pertaining to reimbursement.

(17) Terms of members of the National Professional Standards Review Council should be staggered. Members should be limited to no more than three terms (Section 1163(a)(2)).

(18) The law should be amended (Sections 1151, 1155 and 1160) to provide for PSRO review of care delivered through federal medical programs such as the Veterans Administration and Public Health Service.

(19) Section 1155(b)(4) should be repealed. PSROs would be authorized under Section 1155(b)(4) to inspect the facilities in which care is rendered or services are provided by practitioners or providers. Institutions are currently subject to inspection by the Joint Commission on Accreditation of Hospitals, and, moreover, facilities are generally subject to regulation under state and local law.

(20) Section 1155(b)(3) should be repealed. Practitioners and providers are obligated to maintain supporting documentation substantiating the necessity and quality of care provided under Medicare and Medicaid. These recordkeeping requirements (Section 1160(a)(1)(C)) are duplicated by an ambiguous authorization under Section 1155(b)(3) allowing PSROs to "examine the pertinent records" of practitioners and providers. This authority is, at best, redundant and could be the subject of abuse. Unrestrained examinations of medical records would jeopardize physician/patient confidentiality.

(21) The role of the state medical society should be further augmented by authorizing the Secretary (Section 1169) to enter into contracts with the state medical society, or its designated organization, to provide technical and administrative assistance to PSROs in the administration of the PSRO program.

Under such contracts, the organization would be reimbursed directly by DHEW.

(22) Section 213 of P.L. 92–603, which describes circumstances under which payment may be made under Medicare for certain otherwise noncovered items and services, and under which recovery can be made from providers and practitioners, should be repealed.

(23) Provisions of Section 207 of P.L. 92–603, relating to utilization review procedures under Medicaid, should be repealed.

(24) Section 229 of P.L. 92–603, authorizing the creation of program review teams, should be repealed.

(25) Section 1861(w) and 1815(b) should be amended to require direct payment from Social Security to PSRO for review rather than through fictional agreements with hospitals.

Mr. Rostenkowski. Thank you, Doctor.

I am a little puzzled by your position on disclosure of information. You oppose a general disclosure requirement for shared health facilities as too sweeping, even though this is disclosure of nonconfidential information relating to ownership and financial transactions; and at the same time you oppose disclosure of specific information by PSRO's relating to potentially fraudulent activities and practices. In fact, you seem to be opposed to any disclosure until such time as the Government has already developed the case and is ready to prosecute.

How does the Government ever obtain the information it needs to identify, prevent, and prosecute fraud. Won't your position in effect force the Government into the kind of wholesale fishing expeditions that both you and I want to avoid?

Dr. Beddingfield. On the contrary, Mr. Chairman, it would be our view that the disclosure provisions as written, with the definition of shared health facility, would be a massive fishing expedition with a very closely meshed net. I happen to practice personally in a group. We are not a medicaid mill. We are a very ethical operation, with 22 physicians, in North Carolina.

We would come under your definition of shared health facility. We would be subjected to the disclosure requirements, as would thousands of other legitimate practices across the country. What would the Secretary or the Comptroller do with the information? How do they know not to send us the requirements for disclosure?

To answer your question as to how the Government does get a handle on it, I think we have heard that answered here this morning. I read the testimony of Secretary Califano. He said that they had investigated 45,000 cases without H.R. 3.

I heard the testimony of the U.S. attorney from New York State this morning, who said the information is there in the files and that if they had the manpower and the money and the computers, they could get it out and bring the offenders to justice.

This is precisely what the AMA is saying.

Mr. Rostenkowski. Isn't much of this information available now? Yet you are opposed to further disclosure.

Dr. Beddingfield. I am sorry, sir. I don't understand the thrust.

Mr. Rostenkowski. I am looking for a deterrent in this legislation. Also, I think what we want to do is prevent unnecessary investigations. But we must have access to necessary information. I don't think we, in this legislation want to encourage fishing expeditions. That is principally what I am trying to avoid. I am sure Mr. Rogers is trying to avoid it.

Dr. Beddingfield. I didn't comment on the second part of your question. It escaped me. Excuse me.

We certainly wouldn't be against disclosure once evidence of fraud and abuse surfaced. Certain the Government ought to have every bit of information that it needs to bring lawbreakers to justice. We would support the upgrading of the penalties as a deterrent toward people engaging in this nefarious activity. At the same time, as I have tried to point out, the PSRO should not become a policeman, a law enforcement agency on its own.

The original thrust of PSRO and the presumed reasons for its enactment in Public Law 92-603 was the upgrading and the measurement of the quality of care of services provided under governmental programs. That coupled with education. Nowhere in the original PSRO law was it intended that the PSRO was to become a law enforcement investigative type of agency.

Here we are suddenly changing gears and taking an organization of health providers and saying that you are an investigative arm of the Federal Government. We pointed out there is just beginning to be, due to many reasons, after $2\frac{1}{2}$ to 3 years, some acceptance of the PSRO concept. Funding has been slow coming from the Congress for PSRO's. It's beginning to work. It's beginning to be accepted.

Here we would not—to give it a new and different dimension—that of law enforcement. This is going to cause resentment among a good many practitioners, both those who are members— active members—of the PSRO, and physicians into whose offices they might intrude.

Mr. Rostenkowski. You talk in your testimony about the PSRO's serving as an educational and quality review mechanism. How can it effectively do that if it isn't reviewing physicians' services.

Dr. Beddingfield. Well, first, of all, most of your problems in terms of quality of care and cost of care are based in institutions. The initial thrust of PSRO in the law limited their review to institutional services. That is where the money is. That is where 70-plus percent of your cost is.

PSRO's have not yet developed the sophistication and expertise and methods in accomplishing this first very major task before H.R. 3 would add to that another very, almost insurmountable, task, that of review of outpatient services.

Mr. Rostenkowski. Dr. Carter?

Mr. Carter. Thank you, Mr. Chairman.

What effect do you think this legislation might have on provider participation under medicare and medicaid?

Dr. Beddingfield. Dr. Carter, I would believe that if the potential that we see in H.R. 3 actually came to pass, that every group practice had to register and disclose all of the required information; and if at that point we had a variety of Federal agencies coming into our offices, such as the newly-created Inspector General, such as representatives of the Comptroller General, such as the PSRO, I can foresee that that would not create a favorable climate to the physician who is already at some sacrifice in many, many cases participating at less than his usual fees in these governmental programs. A good many physicians are on the brink already, because of the progressive restrictions, the increased volume of paperwork, the reduction of fees; they are participating in an effort to try to be good citizens and responsible physicians. The addition of teams of Federal inspectors crawling around your premises isn't going to do anything to win friends and influence people.

Mr. CARTER. You are in a group practice, Doctor?

Dr. BEDDINGFIELD. Yes, sir.

Mr. CARTER. How many people do you employ to do your paperwork?

Dr. BEDDINGFIELD. There are 22 physicians. We have a total of 88 other employees.

Mr. CARTER. How many physicians?

Dr. BEDDINGFIELD. I would say in our business office operation, we have one full-time girl medicare, one full-time girl for medicaid, one full-time for Blue Cross, Blue Shield, one full-time for commercial insurance. I would say we have about 20 people employed in our business office operation to handle various third party programs.

Mr. CARTER. How many more would this require you to employ?

Dr. BEDDINGFIELD. The potential is for several more.

I think it would depend upon how much of this came to pass, that the law permits to pass. It would depend upon the degree of implementation.

Mr. CARTER. In your view, do PSRO's have the technological capability to undertake the review of shared health facilities?

Dr. BEDDINGFIELD. Not at this point of time.

Mr. CARTER. Section 3 of H.R. 3 concerns the requirements for disclosure of ownership and business transactions. This legislation states that if an entity does not furnish a significant volume of items and services, it will not be subject to these provisions. In your view what would constitute a significant volume?

Dr. BEDDINGFIELD. That would be a judgmental matter. I would have to study it. I would think if—I would just render this as a personal opinion, because our AMA statement does not cover this specific point—over 50 percent or more of gross receipt came from governmental programs, it would be well to look at that.

Mr. CARTER. Explain to me your expressed fear, of revealing the confidentiality of patient records.

Dr. BEDDINGFIELD. It has been so well documented, Dr. Carter, that once a physician's record is shared with anybody else outside his office, no matter how bound that person is to secrecy, it is no longer—when two people know a secret—a secret.

Mr. CARTER. As a physician, you are in a position to know the secret illnesses of many, many people in influential positions in Government today. Isn't that true?

Dr. BEDDINGFIELD. Yes, sir, this is true.

Mr. CARTER. If we go back over the record——

Dr. BEDDINGFIELD. Some candidates for public office you would know.

Mr. CARTER. Yes, sir. We find that many, many men who have occupied places of prominence in the Federal Government have been victims of some of a variety of disease, such as syphilis, for instance. Is that correct?

Dr. **Beddingfield**. Yes, sir.

Mr. **Carter**. Even some of our Presidents.

Dr. **Beddingfield**. I am not aware of any venereal history of our Presidents.

Mr. **Carter**. A professor stated there were unmistakeable signs of this disease in such a case.

Dr. **Beddingfield**. That could very well be.

Mr. **Carter**. You do not think that you should permit anything to impair the confidentiality of these reports; is that correct?

Dr. **Beddingfield**. That is correct.

Mr. **Carter**. Thank you, Doctor.

Mr. **Rostenkowski**. Mr. Duncan?

Mr. **Duncan**. Thank you, Mr. Chairman.

I want to apologize for not being here at the time you presented your statement. I had an appointment outside. I have reviewed your statement.

I substantially agree with about everything in it. I gather that you just because of the wrongdoing of a few people or the few so-called medicaid mill, that you don't believe that all the others ought to suffer undue punishment because of what a few did? Is that in sum and substance your position?

Dr. **Beddingfield**. That point is correct, Mr. Duncan. We made the further point repeatedly that we believe that adequate laws are on the books for enforcement of fraud and abuse. We would support those. We would agree with those previous witnesses who have pointed out that the knowledge, the data, is there in the files of the medicaid intermediaries, the State agencies. The data for any fraud is there. It needs to be retrieved. That takes manpower, computers. You already have laws that are against fraud. We would support those laws and prosecutors under them. We would applaud the conviction of people who are guilty of fraud.

Mr. **Duncan**. What about the present reports you file. Is that a a burden on the physician's staff and on the general physician himself?

Dr. **Beddingfield**. I am not certain which——

Mr. **Duncan**. The type of reports you must file now without this legislation? Is that a big item in a physician's office?

Dr. **Beddingfield**. As I indicated to Dr. Carter, it takes extra employees. We have different forms for medicare, different forms for vocational rehabilitation, and Social Security, and all the other governmental programs. That avalanche of paperwork does significantly increase the cost of medical care. It takes an extra bank of girls to do it; yes, sir.

Mr. **Duncan**. What percentage—do you have any idea how many physicians might be involved in the medicaid mills that have been reading about?

Dr. **Beddingfield**. In what I conceive to be the medicaid mills as we all saw in "60 Minutes," I would say far less than one percent of the physicians of this country are involved in any such operation.

Mr. **Duncan**. Would you have any idea why these medicaid mills have been mainly in the large cities and not in the smaller communities?

Dr. BEDDINGFIELD. Yes; I do have some ideas.

I think, first of all, most crime is statistically significantly higher in large cities. Second, you have a mass of under-served people. There was a vacuum there, a need for some kind of health care services; and an enterpreneur was able to arrange the premises, was able to make a deal with a commercial lab, was able to recruit generally physicians who were foreign-born or foreign-trained who had difficulty establishing identity and practice in this country. There was a vacuum where it all came together and a law that permitted this.

Mr. DUNCAN. The last couple of days the news media has carried some articles and stories about organized crime being involved in the medicaid mills. Do you have any avenues of discipline to your members if you know that they are actually involved with organized crime in the practice of medicine?

Dr. BEDDINGFIELD. No, sir, I have no knowledge of any involvement of physicians in organized crime.

May I extend that answer just a bit?

Mr. DUNCAN. Yes, sir.

Dr. BEDDINGFIELD. Contrary to what many people in the public think, the American Medical Association doesn't license physicians. As you know, this is a prerogative of the State licensing agencies. In almost every State, conviction of a felony is a reason for loss of one's license.

Now, the American Medical Association has taken certain actions in an effort to help to ferret out those bad apples. Among other activities, we have developed model State legislation which has been sent to the various State medical associations, and indeed has been adopted in a good many States. The bills provide avenues of input regarding unprofessional behavior on the part of physicians, require this to be submitted to the State licensing agency, and give them considerably more flexibility and leeway in disciplinary actions. We are interested in getting rid of these people.

Mr. DUNCAN. My time is up. Thank you very much.

Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Rogers will inquire.

Mr. ROGERS. Thank you.

Dr. Beddingfield, I presume you are not objecting to increase of penalty?

Dr. BEDDINGFIELD. No, sir. We would support that.

Mr. ROGERS. As I understand it, you think that the disclosure provisions might be harmful?

Dr. BEDDINGFIELD. Could be bothersome because they are so sweeping, yes, sir.

Mr. ROGERS. I just read on page ——

Dr. BEDDINGFIELD. Not merely the type of information you are asking for, but particularly the broad base of people to whom it would apply.

Mr. ROGERS. I was just looking at the testimony on page 6. You feel it is not proper to—for the Government to know, for instance, if we are paying to a provider or supplier of services; and it is an institutional provider? You don't think it is wise for us to know to whom we are making the payment?

In other words, to that provider the 5 percent interest in the business?

Dr. **Beddingfield.** Yes, I think it would be wise to know. I think there are other methods of determining that than requiring every group of physicians in the country to bare their souls for the several Federal agencies.

Mr. **Rogers.** Well, I don't know that it would necessarily always be physicians. I don't think it would be, would it, necessarily?

Dr. **Beddingfield.** But the definition of shared health facility would encompass your medicaid mills—a fraction, say of only 1 percent; but 99-plus percent would be legitimate group practices. Therein is our hangup.

Mr. **Rogers.** Well, what is the problem where there is a legitimate operation of knowing who owns it, who is supplying the services? Usually anyone who buys any services is entitled to know from whom it comes. I don't think that is such an unheard of approach.

In other words, I don't see—what is the objection?

Mr. **Peterson.** Mr. Rogers, one of the intentions of the legislation as we understand it, is to get at the entrepeneurs of these medicaid mills. As we see the legislation, with the inquiries here going to the practitioner and with the information that is to be required going to the ownership of the practitioner's practice, the information as such would still not disclose the ownership or the activity of this entrepeneur that you are really trying to get at.

Mr. **Rogers.** I think what we are trying to say is wherever we purchase services, we want to know from whom we are purchasing them. If it is a hidden ownership who is benefiting from payments made, there may be absolutely nothing wrong. What's wrong with having that type of information? I would expect that for any contractual operation. Wouldn't you?

Mr. **Peterson.** Certainly the Government should be able to ascertain from whom they are purchasing the services.

Mr. **Rogers.** Sure. Just ownership. I mean I don't think this is anything saying you have done anything bad or wrong. I don't see any reason not to.

Dr. **Beddingfield.** We would submit that the potential for your disclosure requirements goes far beyond the simple things that the chairman has enumerated such as ownership. For example——

Mr. **Rogers.** Then you would not object to ownership, then?

Mr. **Peterson.** Some of the information that is required goes beyond merely who is the ownership.

Mr. **Rogers.** But you wouldn't object to at least knowing who owned the business if we are purchasing services?

Mr. **Peterson.** As physicians—the physician would be the sole owner of his own practice. As far as other information shown——

Mr. **Rogers.** Well, if it is a group, or a business, is there any objection to knowing—let's settle that point first. Then we will go to the others.

Do you have any objection to that, just knowing who owns the business, who we are doing business with?

Dr. BEDDINGFIELD. If it were limited to that, if it were limited to ownership, I don't believe that we would have any objection.

Mr. ROGERS. I don't think you would have any objection.

What is the further objection?

Mr. PETERSON. The information that would be required here is for—with respect to other business activities which would be ownership of various interests, mortgages, deeds, notes, and other property or assets of the practice as such. They would also want to know the——

Mr. ROGERS. Where is that provided now?

Mr. PETERSON. Page 6 of the bill.

Mr. ROGERS. All right. You would object to revealing what, now?

Mr. PETERSON. Well, Mr. Chairman, some of the information that is required goes beyond merely the ownership of the practice insofar as it would relate to physicians, and insofar as it would relate to group practice; of course, the information would be more extensive. It refers to ownership as to mortgage, mortgages, deeds, trust notes, and obligations; and this would get involved in the personal business transactions of the practice of the group. We have wondered what the connection would be and the necessity or propriety of that information.

Mr. ROGERS. I guess if you get to mortgages, you could get into some problem of ownership there; couldn't you?

Mr. BEDDINGFIELD. Yes. In our clinic we have a mortgage. Part of it goes to the bank, a second mortgage to the life insurance company that helped us build the building.

Mr. ROGERS. Or to another company which we are finding in the medicaid mills. They set up a nonprofit, but they go back in ownership; and ownership in reality becomes a profit organization. Do you think the Government ought to know that?

Mr. PETERSON. Would the Government know from the basis of information that it is a medicaid mill as such? The question is here whether the information should be directed to all organizations or whether it should not be limited in some situations.

Mr. ROGERS. Could you tell us which are abusing, engaging in fraudulent practice and those that aren't?

Dr. BEDDINGFIELD. I believe that information is available in the files of the intermediaries, the carriers, the State agencies. Everybody from those agencies will tell us that it is known who they are. What is needed are the clout and the manpower and the computers to go out and get them. That is the approach. That implementation is needed to process information there in that file.

Information is already there in the files to be acted upon, rather than going out to respectable and honest physicians in this country on a fishing expedition.

Mr. ROGERS. Can you help us to know who is involved in fraud and abuse? AMA?

Dr. BEDDINGFIELD. I think we could help in this respect: I speak now in terms of personal experiences which I am certain have been duplicated in most States across the country. Many times a State agency—in a suspected case—may have evidence of an irregular pattern. They think that this group may be abusing a program.

They are not certain. They will go to their local—their State medical society— and say, will you help us review this profile? What do you think about this?

In every instance medicine has risen to the occasion. We have said, yes, this is wrong, this is not good medicine, this is one you ought to go after; you ought to prosecute this.

Medicine stands ready to provide that type of professional consultive expertise to agencies of Government. We think this is vastly different, however, from sending medicine in the form of PSRO's in as an investigator into a physician's office.

Mr. Rogers. I see what you mean. You are saying then you have no objection to the revelation of ownership, but there should be some showing of fraud before we get into a revelation of other information?

Dr. Beddingfield. Yes, sir.

There is another concern that I have about disclosure also. For example, in that same section Mr. Peterson was reading from, it goes on to say a report of costs and charges for items reimbursed under title V, XVIII, and XIX,

What does that mean to a physician's office? A cost of services and records? What does this do to a shot of penicillin? Are you really going to pursue this to the ultimate to know what the serum cost me, what the penicillin cost me, what the nurse's time cost me, what the sponge cost me, what the band-aid cost me? This could be the result, and Federal programs have been this nitpicking. This frightens me as to the potential of the volume of information that could be required under the bill as drawn.

Mr. Rogers. In other words, instead of just giving the one price, for whatever it may be in the purchase——

Dr. Beddingfield. Well, it says cost and charges. That is the reason I pursued it.

Mr. Rogers. Sure. I don't know. I do think we need to look into this whole matter. We will, since you have raised it.

Should someone have the right, though, when they purchase a service to know what is put aside as cost? I don't know. Should they?

Dr. Beddingfield. Well, in the practice of medicine it would be very difficult to cost account every single service that is given. Attempting to do so would in and of itself inordinately increase the cost of medical care. We would have to have a team of auditors in to do that.

Mr. Rogers. Thank you so much.

Dr. Beddingfield. Thank you, Mr. Chairman.

Mr. Rostenkowski. Thank you.

Dr. Beddingfield. Thank you, sir.

Mr. Rostenkowski. The committee will stand in recess until 1:45.

[Whereupon, at 1:31 p.m., the hearing was recessed to reconvene at 1:45 p.m.]

Afternoon Session

Mr. Rostenkowski [presiding]. The committee will resume its sitting.

Mr. White and Pettengill.

STATEMENT OF WILLIAM C. WHITE, JR., VICE PRESIDENT, PRUDENTIAL INSURANCE CO. OF AMERICA, AND DANIEL W. PETTENGILL, VICE PRESIDENT, AETNA LIFE & CASUALTY, REPRESENTING HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. PETTENGILL. Thank you, Mr. Chairman.

Mr. Chairman, I am Daniel Pettengill, vice president, Aetna Life & Casualty. With me is William C. White, Jr., vice president, Prudential Insurance Co. of America.

We appear today on behalf of the Health Insurance Association of America.

The member companies of the association are responsible for some 85 percent of the private health insurance written by insurance companies in the United States. In addition, 13 of the member companies also serve as fiscal intermediaries and/or carriers for medicare. See attachment A for names.

One key element in the control of fraud and abuse in any insurance system, public or private, is the use of intelligent, observant people in the day-to-day processing of claims. Such people can and often do detect the unusual events or data that constitute the initial clues.

A second key element is the painstaking accumulation of facts that will reasonably substantiate a charge of fraud or abuse. The private health insurance companies in this country do endeavor to perform both of these key elements.

A third key element is conviction and punishment of the persons commiting the fraud or abuse. Here our American system is weak. The courts are often jammed with these and many other types of cases.

In addition, fraud is a very difficult crime to prove and, as a result, prosecutions and convictions are rather infrequent.

Over time, too many untried cases can discourage people from even looking for fraud and abuse, let alone reporting it. It is good, therefore, that Congress is expressing interest in this problem and that H.R. 3 would add more tools, especially those described in sections 4, 7, and 10, to aid in the never-ending struggle against fraud and abuse. We support this bill and urge its passage.

Furthermore, we request your consideration of three additional provisions that would enhance this worthwhile piece of legislation.

First: Extension of PSRO services to the private sector.

When Congress enacted Part B of Title XI of the Social Security Act, it was cognizant of the dangers of two-class medicine and hence did not prohibit Professional Standards Review Organizations from applying the norms of care, diagnosis, and treatment developed for medicare and medicaid beneficiaries to private-sector patients as well.

As yet, few PSROs have taken advantage of this opportunity to serve the entire public. By failing to do so, these PSROs are depriving themselves of significant quantities of data on which to base and test their norms.

Assuming that a PSRO's criteria for estimating the need for and the delivery of good quality care under typical circumstances are effective and economically administrable, then essentially all patients and their insurers should, and we believe would, be willing to pay the cost of screening all cases against such criteria and of having a review made by the PSRO of the exceptional cases that do not meet the criteria.

Accordingly, we recommend that section 5 of H.R. 3 be expanded to provide suitable stimulus for the extension of effective PSRO activities to the private sector.

As a minimum, PSROs should be required to publish their criteria so that carriers could apply them to private-sector patients in those situations where a PSRO was not in a position to do so itself.

Appropriate immunity against damage suits should be granted PSROs that perform exception review for private-sector patients. Where such review is delegated to a hospital by the PSRO, the hospital's costs of making the review should be recognized as a vaild hospital expense by state rate regulatory agencies and by patients and their carriers.

We urge going beyond this minimum to the maximum extent deemed feasible. For example, would it not be feasible to require a PSRO to serve the entire population of its service area if at least three-fourths of the private health insurers operating in the area so requested and were willing to provide the necessary data, do any necessary screening, and pay the expense involved?

Second: Expansion of PSRO boards to include insurer representatives.

We recommend that section 5 of H.R. 3 also be expanded to amend Section 1152 of Title XI of the Social Security Act to require that the board of each PSRO contain at least one representative of the private health insurance companies in order that the knowledge of our business in designing and applying criteria to actual cases might be directly available and in order to facilitate the evaluation of the results obtained by the PSRO.

Section 1162 of this same title XI should be similarly amended to require a health insurance company representative on the board of each statewide PSR council. These two amendments would be desirable even if PSROs continued to serve only the medicare and medicaid beneficiaries.

Third: Notice to beneficiaries of practitioner suspension.

While we support section 7 of H.R. 3 as being a potentially strong deterrent of fraud and abuse under the Government programs involved, we fear that most beneficiaries will not know of the suspension of a convicted practitioner, may unwittingly use his or her services and only then discover that no benefits will be payable under the applicable Government program.

Accordingly, we recommend that section 7 of H.R. 3 be expanded to require a practitioner, during his period of suspension by the Secretary, to notify each patient prior to rendering any service that no benefits would be payable by specified Government programs with respect to that service.

It would then be up to the beneficiary to decide whether he or she was willing to pay the entire fee in order to utilize the services of that practitioner at that time.

If the practitioner failed to so notify the patient, the patient would not be liable for any portion of the practitioner's fee.

As a minimum, the Secretary should be required to place a notice of the suspension in the major newspaper serving the area in which the physician then practiced.

However, this approach would not provide the beneficiaries anywhere near the protection that our recommended approach would because many of the beneficiaries would not see the newspaper notice and because the practitioner might move to a new location where no one knew of the suspension.

In closing, we again want to commend you and your colleagues for your positive efforts to reduce fraud and abuse in the medicare and medicaid program. We pledge the continued cooperation of the Health Insurance Association of America in these efforts.

[Attachment to the statement follows:]

ATTACHMENT A

MEMBER COMPANIES OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA INVOLVED IN THE ADMINISTRATION OF MEDICARE[1]

Aetna Life & Casualty.
Mutual of Omaha Insurance Company.
Nationwide Mutual Insurance Company.
The Prudential Insurance Company of America.
The Travelers Insurance Company.
Connecticut General Life Insurance Company CNA/insurance.
Equitable Life Assurance Society of the United States.
General American Life Insurance Company.
Metropolitan Life Insurance Company.
Occidental Life Insurance Company of California.
Pan-American Life Insurance Company.
Union Mutual Life Insurance Company.

Mr. ROSTENKOWSKI. Thank you, Mr. Pettengill.

Mr. Ford?

Mr. FORD. No questions at this time, Mr. Chairman.

Mr. ROSTENKOWSKI. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

What, if any, areas of fraud or abuse do you feel are not addressed in this legislation or by existing authority?

Mr. PETTENGILL. I think as far as the areas concerned, they are covered. Our one concern, which is a very difficult one, I think, for the Congress to address, is the actual licensure of the practitioner who has been convicted.

Perhaps you ought to consider requiring that a notice be sent to the licensure agency whenever there was a conviction with encouragement of those state agencies to notify you of what action they take with respect to that practitioner.

That would be the one offhand comment I might make.

Mr. CARTER. Would you recommend the same procedure for insurance companies which practice fraud?

Mr. PETTENGILL. What is sauce for the goose is sauce for the gander, sir; yes.

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[1] All of these companies serve as carriers under Medicare Part B (Supplementary Medical Insurance). In addition, the first five companies named also serve as fiscal intermediaries for hospitals, home health agencies, and skilled nursing facilities under Medicare Part A (Hospital Insurance Benefits).

Mr. Carter. Thank you, sir.

If the subcommittee were to decide that PSRO's are not the appropriate bodies to review shared health facilities, what alternative ways would you suggest that we address the problem of medicaid mills?

Mr. Pettengill. Well, I do think that we should continue our efforts to assist the PSRO's to do this job of assuring the American public that quality care is being rendered; and as such, ultimately they should be reviewing all health care.

The fact that we feel that there are certain types of institutions which ought to be looked at earlier than others I think is perfectly appropriate; but if you decide that this is not something that should be assigned to the PSRO's, then my answer is that you assign it to the fiscal intermediaries, because they have the responsibility now, or to the carrier if it is a part B problem.

Mr. Carter. If we should leave it to the PSRO's, you would want membership in that group is that correct?

Mr. Pettengill. We feel that we can be of real assistance to the PSRO. They admittedly face a very difficult problem. We have years of experience; and we think that we could be of real assistance to them in developing criteria and in measuring the results of their efforts.

Mr. Carter. Thank you very kindly.

Mr. Rostenkowski. Mr. Pettengill, why do you think so few PSRO's have been willing on their own to move into the private insurance sector? The law now permits that; and yet they haven't. Do you really feel that Government should encourage this movement now?

Mr. Pettengill. We believe that the Government should encourage them because, as I have said, I think this would give them a broader base not only on which to choose their criteria for their norms, but also to measure the results.

In other words, in some institutions, while there's no question but what medicare and medicaid do constitute a very substantial population, nevertheless they are not the total population by any manner or means; and we think that in judging what are appropriate norms, it would be well to look at the total picture of medical care in that community.

Mr. Rostenkowski. Well, I will agree with that.

Then why haven't they moved into this sector by themselves?

Mr. Pettengill. I must confess I don't have the wisdom of Solomon to answer that question. I think it has been basically that they themselves have not been sure of the method and the procedures that they want to follow; and, therefore, they have been reluctant to expand them beyond that which they have to apply them to.

Mr. Carter. Mr. Chairman, if you would yield on that?

Mr. Rostenkowski. Mr. Carter.

Mr. Carter. Were you referring to PSRO's in this case?

Mr. Rostenkowski. Yes.

Mr. Carter. Isn't it true that they have not moved into this sector because their mandate from Congress was to review the quality and necessity of medical services rendered?

Mr. ROSTENKOWSKI. I am of the impression that the law presently permits them to move into that area. I don't think the Congress or the law has discouraged that. I just wondered why they haven't gone in that direction. There is no law that prevents them from doing it.

Mr. PETTENGILL. It is my understanding that they may do so now. What we are simply saying is any additional encouragement you may deem appropriate would be welcome.

Mr. ROSTENKOWSKI. Thank you, Mr. Pettengill.

Mr. PETTENGILL. Thank you.

Mr. ROSTENKOWSKI. Dr. Allen.

STATEMENT OF WILLIAM E. ALLEN, D.D.S., CHAIRMAN, COUNCIL ON LEGISLATION, ACCOMPANIED BY BERNARD CONWAY, REPRESENTING THE AMERICAN DENTAL ASSOCIATION

Mr. ROSTENKOWSKI. If you will identify yourself, we would appreciate it.

Dr. ALLEN. I am Dr. William Allen, a practicing dentist from Arcadia, Calif., chairman of the council on legislation of the American Dental Association. With me is Bernard Conway, the assistant director for legal affairs.

We are most happy to have this opportunity to present the views of this association. I would like to present the entire statement for the record and summarize.

Mr. ROSTENKOWSKI. Without objection it will be included in the record. You may proceed to summarize.

Dr. ALLEN. Thank you very much.

We support the concept of H.R. 3 to avoid fraud and abuse in the medicare and medicaid systems. We are concerned that the beneficiaries of all these programs receive the highest medical care possible and have access to the providers of this case.

We believe that the overall number of health care practitioners involved in fraud and abuse is very small and that the vast majority of dentists and other health professionals who provide care under these programs is doing so honestly, and in a manner to provide the best care possible for the program beneficiaries.

Any reservations which we have with the particular provisions of the bill before you are based on concerns that they may be unnecessarily and unintentionally burdensome and thus tend to hinder the ability of the majority of practitioners to render care which is satisfactory to the patient and to the practitioner.

It must remain the prime goal of these programs that beneficiaries have access to high quality health care. It is against this goal that efforts to control fraud and abuse which will impose additional requirements on health care providers must be balanced.

H.R. 3 contains, in section 2, provisions generally prohibiting the assignment or factoring of claims for payment under Social Security Act health care programs.

Evidence indicates that the use of factoring increases where medicaid payment is slow. Factoring is one means of overcoming a stagnated cash flow situation brought about by the delayed payment of claims under the medicare or medicaid programs.

It is clear if medicaid is properly administered, factoring would not be significantly indulged in.

In the State of Michigan, where 87 percent of all claims are paid within 15 days and 97 percent within 30 days, no factoring can be found. We are constrained to point out the prohibition of claim assignments will not in itself alleviate the difficulties faced by the health care practitioners in providing sufficient cash flow to enable him to pay for overhead and other expenses.

Improved administrative mechanisms are necessary not only to remove the incentives for practice such as factoring, but also equally important to encourage additional practitioners to participate in the program and thereby increase the access to the program for program beneficiaries.

In this connection, the Senate subcommittee found that only 5 percent of the dentists provided 95 percent of the services under medicaid. We believe that the introduction of efficint administrative mechanisms and realistic reimbursement levels would go far toward remedying this situation.

At the same time, we recognize that factoring is susceptible to abuse and we, therefore, support its prohibition. We note that the Department of HEW already has issued regulations to this effect, and we commend that action.

We are also concerned about the definition of a shared health facility. We would like to have a greater or sharper definition between that and the so-called medicaid mills. We do not want to see a group of three or four private practitioners identified as a shared health facility, put an unnecessary burden on them, paperwork, investigation, if it is not absolutely necessary, and the assocation is willing to assist the Congress or HEW in getting a definition of this facility.

We think that—we appreciate the difficulties in arriving at a definition of a shared health facility which includes all of these entities. We are concerned that a specific definition could result in medicaid mills altering their structures in order to avoid inclusion.

In such cases, the so-called medicaid mills still could be subject to disclosure requirements through the second test offered in the bill, that of providing a significant volume of care under these programs.

In our judgment, this second standard is much more flexible and should be the test for inclusion within a group of entities which could be required to furnish ownership information, et cetera.

It also, I think, must be made clear that the volume of care provided, or the amounts of money received under Federal health care programs is not and should not be viewed as an indication of wrongdoing.

As an example, in San Francisco, a children's dentist was cited in both the papers in San Francisco as earning $140,000 last year under the medicaid program.

It failed to point out, however, in the paper that he had six qualified children's dentists in his office; he had 11 full-time people; he had 14 part-time people; and $140,000 obviously was not all profit.

So we are concerned that this kind of information somehow be—

that the association be contacted or some mechanism be developed where we could have access to it ahead of time and furnish some accurate information on what the actual income was.

We believe that the utilization of adequate administrative procedures and claims processing techniques, the vast majority of cases of fraud and abuse could and should be detected and it is a source of wonderment to us that they are not.

As you may know, in California the system is operated under a name called Medi-Cal. The dental program has been turned over to the California Dental Service.

We are in our second year now. Under this, we are able by computerization to pick up instances where people are abusing the program; we are also—we have not picked up any evidences of fraud to this point, but we find that we are able to administer the program at a significantly lower cost than the State was administering it, so that more money was available for patient care in the long run.

We support the stricter penalties and the upgrading of penalties for fraud, of course. We do have some concern with Congress delegating their subpena authority to the General Accounting Office; but we are sure you are concerned about that, too.

In section 5 of the PSRO amendments, there are several significant changes that have been proposed, including amendments to consolidate the review of area health care services and the local PSRO.

The amendments to remove the review of all service under the Social Security Act, including ambulatory services and amendments to utilize the information gathered by PSRO's to assist in other programs. We feel that these proposed changes are of considerable significance.

However, we must point out what is of primary importance to the dental profession, before other amendments can be supported, the PSRO law should be amended to mandate a formal role for dentistry and review of dental services and development of PSRO policies and management.

As you know, the PSRO law now requires review of all health care services provided under the Social Security Act health programs. The law contains permissive language authorizing PSRO's to utilize the services of dentists in the review of dental care.

However, this is not a mandatory provision and to our knowledge has not been followed yet by any PSRO.

In addition, the law prohibits the inclusion of dentist on the State and National PSRO policymaking bodies. The PSRO law was enacted to utilize peer review concepts to assure the high quality of care provided under medicare, medicaid and maternal and child health programs.

It is as such imperative to us that a true peer review system be implemented. Under such a system, dental services must be reviewed by dentists. We must allow the participation by dentists in policymaking decisions which will affect the dental component of peer review.

Our testimony—the dental profession feels that it really cannot support changes in the PSRO program, particularly changes which would move more quickly to mandate a review of ambulatory care until this serious inequity is rectified.

We urge in the strongest terms possible that the PSRO law be amended to mandate that dental services be reviewed by dentists.

The rest of our testimony outlines additional concerns by the use of the information that is derived by the PSRO's, and I think in conclusion I would just like to thank you for this opportunity.

We would be pleased to try to answer any questions you might have.

[The prepared statement and attachment follows.]

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION BY DR. WILLIAM E. ALLEN

I am Dr. William E. Allen, a practicing dentist from Arcadia, California and Chairman of the Council on Legislation of the American Dental Association. With me is Mr. Bernard Conway, the Association's Assistant Executive Director for Legislation and Legal Affairs. We are pleased to have this opportunity to present the views of the American Dental Association concerning efforts by the Congress to improve mechanisms for identifying and eliminating fraud and abuse under the Social Security Act health care programs.

The American Dental Association endorses efforts to combat fraud and abuse such as those proposed in the legislation before you and pledges its full support in accomplishing this end. The 1976 ADA House of Delegates emphasized this concern by adopting a resolution reaffirming the Association's stand against fraud and abuse in the medicare and medicaid programs as well as in all instances.

Coupled with this concern, however, is an equally strong concern that the beneficiaries of these programs receive the highest quality care possible and have access to providers of this care.

The overall number of health care practitioners involved in fraud or abuse of these programs is very small. The vast majority of dentists and other health professionals who provide care under these programs is doing so honestly and in a manner to provide the best care possible for program beneficiaries. Any reservations which we have with particular provisions of the bill before you are based on concerns that they may be unnecessarily and unintentionally burdensome and thus tend to hinder the ability of the majority of practitioners to render care in a manner which is satisfactory to the patient and to the practitioner.

It must remain the prime goal of these programs that beneficiaries have access to high quality health care. It is against this goal that efforts to control fraud and abuse which will impose additional requirements on health care providers must be balanced.

PROHIBITION AGAINST ASSIGNMENT (SECTION 2)

H.R. 3 contains provisions generally prohibiting the assignment (or factoring) of claims for payment under the Social Security Act health care programs.

Evidence indicates that the use of factoring increases where medicaid payment is slow. Factoring is one means of overcoming a stagnated cash flow situation brought about by the delayed payment of claims under the medicare or medicaid program. We refer you to page 15 of the report of the Senate Subcommittee on Long Term Care for a discussion of the problem of factoring. That report contains a statement by Dr. Emil Lentchner who is the Executive Director of the Eleventh District Dental Society in the State of New York. Dr. Lentchner says "Factoring for collection of medicaid claims is improper and should be regulated. It is clear that if medicaid is effectively administered (which is not the case) to provide prompt payment of claims, 'factoring' would not be significantly indulged in. The clear effect of 'factoring' is to lower the net reimbursement to the health provider—suggesting that the health service could have been provided for an amount less than the 'factoring' percentage. The net result is to 'lower' the quality of care provided to accommodate the decrease in reimbursement." The American Dental Association strongly endorses these comments of Dr. Lentchner.

Dr. Lentchner's comments are buttressed by the finding that in Michigan where 87% of all claims are paid within 15 days and 97% within 30 days, no factoring firms of any consequence can be found. We are constrained to point out then that the prohibition of claim assignments will not in itself alleviate the difficulties faced by the health care practitioner in producing sufficient cash flow to enable him to pay fo overhead and other expenses. Improved administrative mechanisms are necessary not only to remove the incentive for practices such as factoring but also, and equally important, to encourage additional practitioners to participate in the program and thereby increase the access to care for program beneficiaries. In this latter connection, the Senate Subcommittee found that in New York City only 5% of the dentists provided 95% of all dentist services under medicaid. We believe that the introduction of efficient administrative mechanisms and realistic reimbursement levels would go far toward remedying this situation.

At the same time, we recognize that factoring is susceptible to abuse and we therefore support its prohibition. We note that the Department of HEW already has issued regulations to this effect and we commend that action.

DISCLOSURE OF OWNERSHIP (SECTION 3)

It is our understanding that the provisions of this section are aimed primarily at the so-called medicaid mills and are intended to enable the HEW Department to obtain additional pertinent information concerning these entities. This information is to enable fuller investigations into all aspects of the operations of these types of health care facilities in an effort to detect fraud and abuse. We believe that this intent is carried out primarily through the definition of a shared health facility which is designed to include the majority of the so-called medicaid mills.

However, we note that the bill also would require disclosure, at the request of the Secretary, of the pertinent ownership information from all suppliers of items and services, excluding individual practitioners, who provide a significant volume of services under the medicare, medicaid or maternal or child health care programs. While supporting the basic intent of this section, we feel that the language could create some ambiquity as to enforcement since there are references both to shared health facilities as well as to other suppliers of items and services with significant levels of participation in these federal programs, all of which would be subject to these requirements.

We are appreciative of the difficulty involved in developing an adequate definition of a shared health facility which includes all those entities which are of the medicaid mill type and generally excludes the more traditional form of health care practices. We also are concerned that use of such a relatively specific definition could result in medicaid mills altering their structures in order to avoid inclusion in this definition. In such cases, however, the so-called medicaid mill still could be subject to disclosure requirements through the second test offered in the bill, that of providing a significant volume of care under these programs. It is our judgment that this second, more flexible standard should be the test for inclusion within the group of entities which could be required to furnish ownership information.

It must be made clear that volume of care provided or amounts of monies received under federal health care programs is not, and should not be viewed as, an indication of wrongdoing. However, we believe that the federal government is justified in requiring reasonable ownership information of those entities which are receiving significant levels of funds from the government. We believe that use of this, or a similar single standard, will allow the Secretary to obtain information from all medicaid mills. Obviously, we would be depending upon the discretion of the Secretary so that this authority would not be used in a manner which results in overburdening the vast majority of health care practitioners who are practicing ethically.

While we support efforts to obtain this ownership information, modified as we have suggested above, we believe that the primary and most effective thrust which can be made against fraud and abuse of these programs should be through the administrative mechanisms utilized in these programs. We have already referred to problems in receiving reimbursement in a timely manner. We also believe that through the utilization and adequate administrative procedures and claims processing techniques the vast majority of cases of fraud and abuse could and should be detected. It is a source of wonderment to us that they are not. To a great extent we feel that the review and investigative and enforcement authority already is sufficient for control of much of the current fraud and abuse. Activities of the newly established Office of Inspector General could go far towards spurring investigative activities. We reiterate our hope that further efforts can be made to improve the efficiency of the administrative side of these programs.

PENALTIES FOR FRAUD (SECTION 4)

We believe that the prevention of fraud and abuse problems under these programs could be significantly assisted through the imposition of significant penalties for those who are found guilty of such practices. We support the provisions in this bill increasing these penalties.

SUBPENA AUTHORITY (SECTION 6)

Unless there are difficulties with the ability of the General Accounting Office to obtain needed information with which we are not familiar, we do not think it necessary or proper that the Congress should surrender its jurisdiction over reviewing and granting subpenas to obtain information which the Comptroller General deems necessary. We doubt seriously that the Congress has denied any legitimate request for subpenas from the Comptroller General and feel that, as an arm of the Congress, the GAO should report to and get the approval of the Congress before acting in areas such as the issuance of subpenas.

PSRO AMENDMENTS (SECTION 5)

H.R. 3 proposes several significant changes in the PSRO program including amendments to consolidate the review of area health care services in the local PSRO, amendments to move to PSRO review of all services provided under the Social Security Act health care programs including ambulatory services, and amendments to utilize the information gathered by PSRO's to assist in other programs.

We feel that these proposed changes are of considerable significance. However, we must point out that it is of primary importance to the dental profession that, before other amendments can be supported, the PSRO law be amended to mandate a formal role for dentistry in the review of dental services and in the development of PSRO policies and management. As you know, the PSRO law now requires review of all health care services provided under the Social Security Act health programs. The law contains permissive language authorizing PSROs to utilize the services of dentists in the review of dental care. However, this is not a mandatory provision and to our knowledge has not yet been followed by any PSRO. In addition, the law prohibits the inclusion of dentists on the state and national PSRO policy-making Councils.

The PSRO law was enacted to utilize peer review concepts to assure the high quality and necessity of care provided under medicare, medicaid, and the maternal and child health program. As such it is imperative that a true peer review system be implemented. Under such a system, dental services must be reviewed by dentists. In addition, such a system must allow for the participation by dentists in policymaking decisions which will affect the dental component of peer review.

The Association has appeared before Committees of Congress on numerous occasions to discuss this inequity in the PSRO law. Rather than review the evidence of the extensive role which the dental profession plays in the delivery of health care both in hospitals and on an ambulatory basis, the extent of this role in public programs, and the unique role which dentistry plays among the various health professions, I would refer you to the attached testimony which recently was presented by the American Dental Association to the National Professional Standards Review Council. I must say again that the dental profession cannot support changes in the PSRO program, particularly changes which would move more quickly to mandated review of ambulatory care, until this serious inequity in the existing law is rectified. We urge in the strongest terms possible that the PSRO law be amended to mandate that dental services be reviewed by dentists and that dentists have membership on the state and national Professional Standards Review Councils.

In addition to moving toward review of ambulatory and other noninstitutional services, the bill would amend the PSRO law to require that PSROs provide data and information to state and federal investigating agencies and to health planning agencies. Again we must emphasize that the success of the PSRO program will be conditioned on its maintaining true peer review or peer education concepts. We are very concerned that requiring PSROs to supply information, particularly to investigating agencies, will change the purpose and nature of a PSRO from an educational and quality control entity to an investigational one.

If such a distortion should occur, we think it might damage the ability of PSROs to carry out their primary functions. We think it is clear that full and free discussion of the practice techniques of various individuals will be seriously hampered if results of these discussions and the information obtained from them is to be turned over to an investigatory unit. We urge that such a requirement not be included in the language of any final legislation.

We feel that it is likely that some information developed by PSROs could be of assistance in health planning activities. However, we would like this language to assure the confidentiality of such information and to restrict the information provided to health planning agencies to those types which are of direct assistance in health planning.

In conclusion we thank you for this opportunity to present our views on these important issues. We offer our continued assistance in the development of this and similar legislation. I would be pleased to respond to any questions the members of the Committees may have.

ATTACHMENT

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION AND THE AMERICAN SOCIETY OF ORAL SURGEONS NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

Mr. Chairman and members of the council, my name is Dr. Joseph M. Kelly of Worcester, Massachusetts. I maintain a dental practice in that city, limited to oral surgery, and presently am serving as well as a member of the Council on Hospital Dental Services of the American Dental Association.

Accompanying me is Dr. Terry Slaughter of Salinas, California, a private practitioner and President-Elect of the American Society of Oral Surgeons.

We recognize and are sympathic with the problems of the Council and staff in dealing with the complexities and controversies involved in the implementation of the professional standards review program. We are therefore especially appreciative to your willingness to give us this opportunity to present to you yet another problem that is of serious concern to the members of the dental societies we represent.

We are here to solicit your active cooperation to eliminate the existing inequity or deficiency under Public Law 92–603 that on the one-hand mandates the review of dental services, and on the other, has been interpreted to exclude dentists from the process.

The language and legislative history of the PSRO law shows a clear intent that such inequity should not occur. Our purpose here, today, is to urge that the PSRO program provide full participation and representation for dentists in its development and operation. We are requesting your support of our efforts to accomplish this goal.

We would submit that it is clearly discriminatory to allow the law and its implementation to stand as at present. It is wholly contrary to any rational understanding of peer review to mandate review of dental services without a mandate of equal force that dentists shall conduct such review. Allowed to stand, it will prove a crippling defect to the full acceptance of the law. The artificiality of the present arrangement will become even clearer and more crippling as ambulatory services are given closer attention. We believe it is in everyone's best interest to rectify the matter now.

Dentists are professional providers of primary oral health care and are duly licensed in every state and jurisdiction in the nation to provide such care. We can find no legal decision, federal or state law, or federal or state regulation that implies otherwise.

There are, today, some 100,000 members of the profession engaged in the private practice of dentistry. More than 100 million people annually seek their services. According to the most recent estimates released by the Social Security Administration, some $8.6 billion was expended during 1976 for dentists' services. Of this total, the same source estimates that some $469 million was public expenditures, much of it under Titles V, XVII or XIX of the Social Security Act.

These basic characteristics of dental practice—independent licensure, provision of primary care, 100 million patient visits and large-scale expenditures—are fundamentally identical to those of physicians. No health occupation other than these two has this combination of characteristics.

Further, dentists are actively engaged today in providing care within hospital and other institutional settings. According to figures compiled by the American Hospital Association, more than 3,000 hospitals today have organized dental services either free-standing or as sections within departments of surgery.

Data available through the American Dental Association's Council on Hospital Dental Services indicate that some 3 percent of the total admission to hospitals today are for dentally related services. More than 15,000 dentists regularly admit patients to hospitals.

We have, over recent months, made a number of efforts to obtain additional, independent verification of the procedures performed within hospital settings by dentists. The Commission on Professional and Hospital Activities estimates that nearly 5 percent of hospital admissions for the 2,700 hospitals participating in the Commission's program were for dental or oral surgical procedures. The National Center for Health Statistics' Division of Health Resources Utilization Statistics Branch estimates that more than 550,000 operations were performed in hospitals by dentists in 1974.

The American Society of Oral Surgeons has made available to the National Center lists of the procedures dentists are licensed to perform and of the diagnoses in which the dentist might play a primary role. The Center indicated that there were about 1.1 million first-listed diagnoses under which the dentist might provide treatment and some 2.2 million conditions in the treatment of which a dentist might be involved.

The Accreditation Manual for Hospitals issued by the Joint Commission on Accreditation of Hospitals states that medical staff membership shall be limited to individuals who are fully licensed to practice medicine and, in addition, to licensed dentists.

The Joint Commission defines an organized medical staff as a formal organization of physicians and dentists with the delegated responsibility and authority to maintain proper standards of care. Its manual stipulates that dentists who are members of the medical staff may admit and discharge patients.

These, then, are a selection of the various facts and judgments attributable to non-dental organizations. Without question, they fully support the position enunciated in the opening paragraphs of this statement.

In light of the nature and extent of dental services subject to the mandate of Public Law 92–603, the question is how are dentists to be brought into the structure of the organizations established to carry out the purposes of the law.

In the summer of 1976, your Council's Executive Secretary issued an invitation to both our organizations to become members of the liaison network of non-physician health care providers. Both organizations declined the invitation.

I want it to be clearly on the record that our action did not stem from an adverse view of the liaison network. Indeed, it has been highly effective to date and we believe that the members of the liaison network, the Department, and this Council deserve the highest commendation for the foresight that led to its establishment. That said, however, the fact remains that the liaison network is not the proper mechanism for dental participation. Full participation in developmental and operational phases of the program and eligibility for Council membership is the proper mechanism.

The history of activity by the dental profession that has led us to seek this appearance is long-standing. I will not burden you in this statement with all of its details but will only note a few points.

Nearly five years ago, in February, 1972, the American Dental Association appeared before the Senate Finance Committee during its consideration of the proposals leading to this law. At that early date, the Association offered amendments to the proposal that, among other matters, would have provided for equitable representation of dentists. During that appearance, Senator Wallace Bennett commented to our witness that "the language of the bill as it is finally adopted, if any peer review is adopted, will make sure that only dentists review the work of dentists . . ." (Senate Finance Committee Hearing, February 7, 1972, p. 2418).

As finally written, of course, the law does not assure this, though there is language in Section 1155(b) that is permissive and clearly intended to partially serve the purpose enunciated by Senator Bennett:

"To the extent necessary or appropriate for the proper performance of its duties and functions, the Professional Standards Review Organization serving any area is authorized in accordance with regulations prescribed by the Secretary to

(1) Make arrangements to utilize the services of persons who are practitioners or specialists in the various areas of medicine (including dentistry) or other types of health care which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their professions within the area served by such organization"

In addition, the Finance Committee Report on the legislation (Sen. Report 92–1230) on p. 265 states "It is expected that PSROs would make specific arrangements with groups representing substantial numbers of dentists for necessary review of dental services". The Report makes clear that such arrangements are to be for independent review and are to be differentiated from arrangements with other nonphysician health care practitioners.

While appreciative of the intention embodied in the law and the Report, this has not resulted in true dental peer review and has not permitted active dental participation in the implementation of the PSRO program.

In the years since, the Association has made a number of appearances before Congressional committees on this legislation or closely related matters. We have repeatedly taken note of the problem posed by the present law. We have conferred on various occasions with all of the appropriate senior officials of the Department. We helped develop and supported during the 94th Congress a bill, S.153, designed to remedy this and other defects in the law. With, we think, considerable patience, we have sought the necessary changes.

We appear here today to give the Council personal notice of the dilemma in which we are placed. We would specifically ask the Council to take the following steps. First, we would ask it to take formal, public action giving its support to changes in the law. Secondly, we would ask the Council to request formally from the Department a public statement of its willingness to cooperate in this effort. Finally, we would ask the Council to invite the dental profession to occupy an observer status, with the right to enter into discussion, within the formal structure of the Council's proceedings as a temporary measure pending legislative changes.

Every member of this Council is a health professional. We fully expect you to carry out your responsibility to scrutinize fully the testimony we are offering and to request of us any additional data that you wish. We hope you would find it possible to do this in as timely a fashion as possible.

Once done, we are confident you will agree that, had your professional discipline been placed by law in the position in which dentistry finds itself, you would come before this Council just as has dentistry.

Mr. Chairman, this concludes our statement. We would, again, like to express our appreciation at your courtesy in inviting us to appear. Dr. Slaughter and I would be glad, now, to respond to any questions.

Mr. ROSTENKOWSKI. Thank you, Doctor.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I compliment you on your presentation. Certainly I feel that you should be included as members of the PSRO's and that when dental services are reviewed, you should compose that review team.

I believe most physicians would be at a loss in determining the quality of services rendered by dentists and also would be at a loss as to prices to be charged and so on. Your request in this area is quite reasonable.

Thank you, sir.

Dr. Allen. Thank you.

Mr. Rostenkowski. Would you also endorse mandating the membership of other health care disciplines such as the nursing profession?

Dr. Allen. Well, we know that this has been a question before your committee before, who should be on these. We think that dentistry performs a significant volume of service, of direct care to the patient. It is also a service that has no analogy within medicine. Certainly you could have optometrists and the analogy might be ophthalmologists. In dentristy, there is no other such group that takes care of the oral health needs of the patient.

Therefore, we think because of the specificity of the kind of work that we do, the need for having to be judged by our own peers in this particular instance, and the volume of dental care under these programs, we feel that we need to be involved in the planning of these programs, if they are going to be successful.

I would assume if the nursing association can make as strong a point, that they should be included also.

Mr. Rostenkowski. Thank you, Doctor. Thank you for joining us this afternoon.

Dr. Allen. Thank you.

Mr. Rostenkowski. Dr. Coleman.

STATEMENT OF ARTHUR H. COLEMAN, M.D., PRESIDENT, AND ALFRED F. FISHER, EXECUTIVE VICE PRESIDENT FOR ADMINISTRATIVE AFFAIRS, REPRESENTING NATIONAL MEDICAL ASSOCIATION

Dr. Coleman. I am Arthur H. Coleman, M.D., president of the National Medical Association.

To my right is Mr. Alfred Fisher, executive vice president of the NMA.

Our statement is relatively brief. If you don't mind, I would like to read it into the record.

Mr. Rostenkowski. Go right ahead, Doctor.

Dr. Coleman. About 30 years ago, when I began the practice of medicine, penicillin was hardly available and sulfa drugs were of limited effectiveness. Thus, many illnesses were still being treated by shotgun prescriptions, that is, if one added enough drugs to the prescription, one of the drugs would, hopefully, cure the problem.

Today medicine has developed to the point of a single specified drug for certain conditions with relative assurance that the medication will be effective.

The NMA is, therefore, somewhat distressed that our Congress in 1977 is suggesting a shotgun approach to the fraud problem in medicaid. One would believe that the U.S. Government has the sophistication through science, computer systems, and trained personnel, to tackle most problems in a specific and direct manner.

I am happy to add from the testimony I heard this morning, obviously the capability is available. It is a question of financing such resources.

The proposed H.R. 3 bill impugns, in a general way, almost all physicians who happen to practice in a low-income area. The objective of H.R. 3 is, I suppose: "If we gather all of you in one barrel of glut, those who are innocent will somehow come out of it smelling like a rose."

The fact is, however, that those who are most devious or possess the greatest ingenuity will probably be the ones to escape, more so than the innocent.

I would like to be specific at this point and challenge the definition of "a shared facility." The present definition fails to consider those medical facilities established before medicaid was enacted. Is there going to be a grandfather clause in the bill for such facilities?

There are many people committed to providing health care to the poor who through their own investments did establish health facilities prior to 1965.

It would appear that these individuals are now being cited out.

Second, there is an inconsistency in our national policy on health. We spend money and time recruiting minorities from the inner cities to go to medical school, with the implied understanding that they are expected to return to their respective areas.

We must now tell them, once they become physicians, that if they go back into these areas, work long hours and try to provide a comprehensive service to the people, a burden may be placed upon them; they must stand ready to prove that they are not committing fraud, since 50 to 90 percent of their income may come from either title V, XVIII, or XIX funds.

Third, the figure of an aggregate of $40,000 received in a year from title V, XVIII, or XIX is too low and grossly unfair. A practitioner who has 80 percent medicaid patients might easily gross $40,000 in a year. However, the expenses for practicing with a predominance of such patients due to the paperwork, low fees, frequent rejection of claims, and delayed payments, could easily run 55 to 60 percent in contrast to a 40 to 45 percent overhead in the private sector.

Therefore, 55 to 60 percent of $40,000 is netting that physician only 16 to 18,000 pretax dollars for the year. The NMA proposes in place of a dollar figure that the bill should substitute "substantial in amount" to be defined for each geographic area as stated in accordance with regulations of the Secretary of HEW. The Secretary should be required to consult with a physician association fully representative of physicians practicing in the area and who receive at least 50 percent or more of their income from titles V, XVIII, and XIX.

The idea would be not to set arbitrary limits, but to have HEW look at each locality and then set a cutoff point in the regulations which would then have some equity.

As the bill presently stands, a physician who sees very few medicaid patients could be just as guilty of fraud as one who sees many, but under H.R. 3 he would very easily escape surveillance.

Fourth: The NMA feels that legitimate professional groups should be excluded and would propose that the bill preclude "an arrangement under which two or more health practitioners practice their profession as a partnership, professional service corporation, or other legal entity."

Fifth: With respect to the PSRO amendment portion, it would appear the bill shifts PSRO responsibility for inpatient services to ambulatory care services where there are a large number of shared facilities.

The NMA is quite concerned about this in that PSRO is still in its early development. Most PSROs have been set up either without representation from NMA members, or the input from black physicians has been minimal.

There is no way for many of those PSROs to either understand or appreciate that the mode of practice in the inner city has to be different due to the lifestyles of the people therein.

As an example, a physician can't wait for a throat culture to come back from the laboratory before instituting treatment. The no-show for follow-up care is so high in many low-income areas that the attending physician must treat not only immediately, but intensively so. Patient compliance is often poor in these areas; hence, injections are sometimes given more frequently than prescriptions for infections.

Therefore, again there should be a provision requiring any PSRO reviewing such ambulatory care facilities to include representation from physicians who are practicing in the immediate area, although they cannot review their own cases.

Finally, what is the real purpose of the bill? It is really to seek out fraud, or is it to control cost? True, fraud may be a factor contributing to the high cost of present-day medical care, and certainly the NMA is opposed to fraud for whatever reason. But there are other factors causing the increase in cost of medicaid and medicare. We recognize that today physicians are prime targets for criticism, but few people are going to say anything about the consumer.

We would, however, like to raise the question about patient overutilization as a cause of increased health care costs: the mother who takes her three children to the emergency room at 6:30 p.m. for mosquito bites—the cost of which was $35 per child; or the medicaid patient who has two and three abortions in a year.

In one of our health plans, we found 31 percent of the women who had abortions had as many as two and even three in 1 year.

Let me make the record clear that we are not opposed to a mother getting treatment for her children or the right of a woman to have an abortion, but there is a need for an educational and outreach program for many medicaid patients.

Then there are a number of patients who support their drug habits of barbituates and codeine by a medicaid card which allows them to hop from one physician to another.

If we are really talking about fraud and not cost control, should there not be something in the bill concerning fraud on the part of any State? I have reference to any State which makes a practice of not paying physicians regularly and promptly, but hold on to the moneys to collect interest, leaving the provider to suffer in the payment of his bills.

Is this not a form of fraud? When the State does decide to pay its providers, one might easily get $5,000 in any 1 month, but practically nothing the next 2 months.

In conclusion, the NMA believes the intent of the bill is certainly honorable, but the approach to the problem is both obsolete and inequitable. There is already sufficient data and the ability to collect data to show patterns of utilization for both providers and recipients. We urge that the bill provide for the investigation of those who are beyond a range established to be normal as targets in the investigation for fraud and abuse.

I believe the testimony this morning by the attorney from New Jersey indicated a similar approach.

Let us not incriminate physicians because they happen to be practicing in a low-income area. I assure you, if we persist in witch hunting and harassment of the majority physicians practing in heavily-populated areas of medicaid recipients, few will set up practices in these areas to treat the poor. Is this really what we are after? I certainly hope not.

Mr. ROGERS [presiding]. Mr. Rostenkowski?

Mr. ROSTENKOWSKI. No questions.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I wish to thank the gentlemen for their excellent testimony.

Mr. ROGERS. Mr. Duncan?

Mr. DUNCAN. No questions. Thank you, Mr. Chairman.

Mr. ROGERS. Let me ask this: Of course, we know of your association. Are you doing anything, have you got any committees set up or any program going to try to do something about fraud and abuse in these programs? I just wondered if you did?

Dr. COLEMAN. No; we do not.

Our organization is small. Resources are limited. We are on record at our last convention being opposed to fraud.

We had a recent case in Los Angeles in which two physicians were arrested allegedly for fraud in the medical program. The position of the MNA was this: We took exception to the manner in which they were arrested. One was taken out of the shower and forced downtown. The other was taken out of his office while examining patients. We certainly were opposed to that approach. We made no comment about the allegations of fraud. We feel the legal processes should take care of that matter.

Mr. ROGERS. Has your organization noticed what they feel is significant abuse of the program?

Dr. COLEMAN. I think we have seen—well, there's abuse, obviously, on both sides. We have certainly seen abuse in terms of patient overutilization.

Mr. ROGERS. Is there anything we can do, you feel, to get to that problem?

Dr. COLEMAN. I think we need to establish our norms and then through computer systems, profiles, patient activity, we can begin to spot such patients.

Mr. ROGERS. Thank you for your helpful testimony. We appreciate your being here.

Dr. COLEMAN. Thank you.

Mr. ROGERS. The next witness will be the Physicians National House Staff Association, represented by Daniel Asimus. I am sorry.

It is a panel. The Illinois Physicians Union, represented by George L. Lagorio; and the Cook County Physicians Association, represented by Carell Hutchinson.

Your prepared statements will be made a part of the record in full.

You may proceed as you desire. You might identify yourselves for the reporter. In reporting it, you will be sure he is ascribing remarks to the correct person.

A PANEL CONSISTING OF DANIEL ASIMUS, M.D., PRESIDENT, PHYSICIANS NATIONAL HOUSE STAFF ASSOCIATION, ACCOMPANIED BY JEFFREY P. NADLER, M.D.; GEORGE L. LAGORIO, M.D., PRESIDENT, THE ILLINOIS PHYSICIANS UNION; AND CARELL HUTCHINSON, M.D., COOK COUNTY (ILL.) PHYSICIANS ASSOCIATION

STATEMENT OF DANIEL ASIMUS, M.D.

Dr. ASIMUS. Mr. Chairman, thank you for the opportunity to address your joint committee on H.R. 3. I am Dr. Dan Asimus. I am currently president of the Physicians National House Staff Association. I am a full-time elected officer of our organization. Our headquarters are here in Washington, D.C.

The PNHA is a national professional union of interns and residents. We represent more than 11,000 training physicians who are employed in hospitals and clinics nationwide. We work in these hospitals day and night, often over 100 hours per week with shifts of 36 hours straight. Eighty percent of our time is spent in direct patient care. The remainder is spent teaching medical students and fellow housestaff physicians and attending lectures and medical rounds.

We are the hospital physicians of today and the practicing physicians of tomorrow. We speak today in favor of H.R. 3 and suggest that even stronger provisions are necessary. Obviously, Federal laws and regulations are necessary in order to deter and curtail hospital and clinic administrators and physicians from engaging in fraudulent, dishonest, and illegal practices. We must end these scandals, allocate sufficient funding for PSRO, and get on with properly caring for patients. We do not want to have our futures as young physicians scapegoated and destroyed by a few dishonest administrators and health providers who are cheating, lying, and ripping off the scarce health care dollars.

We support the ban on the use of factoring arrangements.

We would like to mention here as an aside that in Arizona they have a medical services plan which is a Statewide fund that collected moneys for medicare and medicaid patients and also other moneys from health care go into this Statewide fund. We are disappointed that there was very little consumer input into the utilizations, therefore, from this fund, this medical service fund in Arizona. We consider this a slush fund, that all of the interns and residents and practicing physicians who work for Arizona have to sign an agreement with the State before they are given the contract for employment. The moneys go from their services into this fund which, like I say, there is very little consumer input or physician input as to how those funds would therefore be utilized after that period of time. We suggest that systems like this have more consumer input and that they be investigated.

There will be less fraud and abuse if shared health facilities reveal a list of their investors, board of directors, and major business transactions. We support the PSRO's reviewing shared health facilities and agree with the provisions which will increase the efficiency and effectiveness of the PSRO's.

I, myself, when I was a resident at Los Angeles County Medical Center was part of a group of interns and residents that started a PSRO in Los Angeles. This was a time when the Los Angeles County Medical Society was determined to prohibit any PSRO's from Los Angeles. We, the interns and residents, knew that PSRO was going to be a beneficial review system for physicians, particularly in the county hospitals. We ourselves petitioned for the grant and were given the grant to start the PSRO there.

Harsh penalties for fraudulent activities under medicare and medicaid will serve as additional deterrents for future abuse and we agree that penalties should be upgraded to felonies. These offenders should be prosecuted, and where appropriate, lose theeir licens to practice and be prohibited from participating in future medicare reimbursement programs.

H.R. 3 does not go too far. In fact, it doesn't address the most severe and costly area of abuse in the medicare-medicaid system. I am referring to the incredibly inefficient and wasteful ways our hospitals are administered and operated.

As Congress and the press concentrate on the double-dealing kickbacks and medicaid mill scandals, this country's 60,000 intern and resident physicians daily become angry and outraged with this mismanagement and callous indifference within our hospitals. H.R. 3 is needed but it only scratches the surface in an attempt to save money, eliminate abuse, and improve patient care. If you are really interested in improving health care and containing the skyrocketing medicare-medicaid costs you will look more closely at the way our hospitals are operating.

I recently completed my training at Los Angeles County-USC Medical Center. Up to 20 percent of the X-rays were lost or misplaced within 24 hours. Consequently, patients had to be reexposed to radiation and double billed. Approximately 30 percent of the time the medical charts would not be available for patients in the outpatient department. Patients had to be rescheduled and recharged. Hospital personnel frequently waste dressings, drugs, and other supplies simply because insurance will cover it. Lab results are frequently lost or the blood tubes misplaced necessitating additional costs, financial expense, and frequently extended hospital stays. Patients are admitted to the hospital for minor tests and procedures simply so that insurance will pay for them. Followup care for patients after they leave the hospital is often faulty or absent. This frequently results in further illness and rehospitalization.

We, the interns and residents are a part of this system and we are not proud of it. We are unable to practice good medicine because of the widespread administrative incompetency. PSRO's are intended to identify and eliminate these abuses but we doubt that they will. The interns and residents, within the Physicians National Housestaff Association, are making improvements through the process of collective bargaining. We are demanding recognition and substantive change even though the National Labor Relations Board last year erroneously defined us as students and not employees.

We need to make hospitals and clinics more fiscally accountable if we really want to address fraud and abuse in the medicare-medicaid system. PSRO's must be adequately funded and staffed. We had difficulties with that in the PSRO I mentioned earlier in Los Angeles, getting funded and staffed.

Housestaff physicians must involve themselves in the PSRO's and fight hard at the bargaining table to eliminate the waste and abuse within our hospitals. We have difficulty overcoming the opposition of the AMA and State medical societies.

All health care professionals must start working together within hospitals realizing their responsibilities and start sharing the responsibility for trying to rectify these abuses. Consumers must get more involved in PSRO's and demand resolution of some of these problems. The Government must demand high administrative standards for themselves and our hospitals.

The young physicians of today are prepared to demand a high standard of medical and ethical excellence. We agree that safeguards are necessary to prevent fraud and abuse. We believe that health care is an universal right and that both the hospitals and ourselves must be accountable.

Thank you.

I would now like to introduce Dr. Jeffrey Nadler, who is a regional representative from New York with the Physicians National Housestaff Association.

Mr. Rogers. Thank you very much.

Dr. Nadler, you may proceed.

STATEMENT OF JEFFREY P. NADLER, M.D.

Dr. Nadler. Mr. Chairman, I want to thank you for the opportunity to address the committee on so important an issue as medicare medicaid abuse.

My name is Jeffrey P. Nadler, M.D. I am a resident in internal medicine at New York Medical College/Metropolitan Hospital Center in New York City, a member of the house of delegates of the Committee of Interns and Residents and regional representative of the Physicians National House Staff Association.

We feel that adequate health care services to maintain the quality and quantity of life must be adequately funded. Funds are short, and the financial base of the health care dollar is at a critical level. Our position as professional employees of the New York City health care delivery system permits us to see much. There are massive problems in New York City health care delivery. There are two populations whose needs must be satisfied. One population can either afford the costs or cover them through third party insurance. The other population is medically indigent, hence medicare medicaid to assure the provision of services.

The existing health care system in New York City by its very nature fosters abuse, either intentional or not. An examination of this system may lead to some constructive realignment. This involves the relationship between the municipal, voluntary and proprietary hospitals, nursing homes, health-related facilities, and private practitioners.

The municipal hospitals maintain affiliation agreements with many of the voluntary hospitals for provision of professional services. This generally upgraded the standard of care in municipal institutions, as it was intended to do, but it has proven a source of extensive profit to the voluntaries. There is a process of skimming by the voluntaries that involves locating profitable, highly reimbursible services, such as complex diagnostic services, radiotherapy units, elective surgery, et cetera, primarily at the voluntary hospital. The financial benefit is obvious. This further discriminates: patients transferred for these services are a steady source to maintain high occupancy rates at the voluntaries. The basic care, basic diagnostics, emergency care and later outpatient care which are the extremely expensive hospital services rendered, are largely left to the municipals. These services are the money losers and cause the need for additional Government support. This is an abuse of the affiliation contracts, of medicare medicaid and those to whom coverage is offered.

An even more invidious process is dumping. This is the transfer of a medically indigent person to another hospital, preferably a nonaffiliated municipal hospital, because of lack of beds. Mount Sinai dumps on Metropolitan New York Medical College affiliation, Columbia-Presbyterian—which staffs Harlem Hospital—dumps on the Bronx and so on. This again puts the financial burden on the municipal institution.

Most importantly, a tremendous source of abuse arises through deficiencies in management and planning. The hospitals suffer a cumbersome bureaucracy, with poor ordering and distribution leading to shortages of drugs and supplies; delays in patient care and improvisation with what's available leads to prolonged hospitalization and gross waste. CIR has previously documented many instances of waste and shortage. There is also a misallocation of personnel. Cuts and hiring freezes have led to inadequate numbers of radiology and laboratory technicians, causing delays in diagnostic workups and again prolonged hospitalization.

Administration is topheavy and not developing more efficient systems operations. Layoffs of clerks, secretaries, and librarians lead to no charts showing up in clinics or no current data being available on the charts when the charts are in clinic. This causes repeat tests and visits that may not have been necessary—all billed to medicare medicaid. Modern systems and management with less bureaucracy would greatly relieve these unnecessary costs. Recommendations from a regulatory agency with broad experience would help. We have in mind the PSRO's.

We are impressed with the number of hospital admissions of questionable necessity. It is hard to justify an acute care hospital admission for disposition. There are many, and transfer to other facilities is impeded by bed shortages and administrators unwilling to risk a failure of reimbursement. It takes months for a new patient to enter the medicare medicaid system, at best, and the fear of unreimbursed expenses is understandable, although this is often not the apparent motive. We know of one hospital where the head of the PSRO is also director of the emergency room and directly responsible for the majority of admissions. The abuse potential is apparent. A strong, third-party review system is needed.

It is exceedingly difficult to imagine the degree of abuse or possibly outright fraud at the proprietary institutions. This also applies to nursing homes, health related facilities, et cetera. Control and supervision is minimal from the patients that are transferred to our care. Accountability must improve at this level.

This raises the area of private physicians and other services. At best one can say reimbursement rates are inadequate. Many physicians, pharmacists, and other health professionals assiduously avoid medicare medicaid patients; others render their service and recoup their losses through heavier fees for nonindigent patients. Others, hopefuly in fewer numbers than the press imply, deplorably run mills—rapid patient turnover yields profits through efficiency. This is especially evident in methadone clinics, where physicians are reported to bill for services questionably rendered. The standard of care is generally poor, but in the inner cities this may be all that is available—municipal hospital clinics are backed up months for appointments, and theer are no other alternatives. This is a heartrending situation for those of us committed to quality, humanitarian care.

In summary, excessive bureaucracy, poor management and systems, relative or real financial discrimination encourages skimming, dumping, mill operations, inefficiency, and waste. The altruistic and necessary goals of existing medicare-medicaid legislation is thwarted. We support efforts to improve management and eliminate abuses.

We would recommend extending the PSRO provisions, strengthening them, and making them more independent.

Mr. Rogers. Thank you very much, Dr. Nadler.

STATEMENT OF GEORGE L. LAGORIO, M.D.

Dr. Lagorio. Mr. Chairman, the remarks made by the young physicians next to me bring back the idealism that I had 20 years ago in my training at Cook County Hospital in Chicago. After 20 years of experience, I am sure that their idealism is going to meet the reality of frustration in trying to deal with the department of public aid in a State. I am Dr. George Lagorio, president of the Illinois Physicians Union. We have approximately 350 physicians in our organization; a large number of them handle a large volume of public aid recipients. To my left is Dr. Carell Hutchinson, Jr., who represents the Cook County Physicians Association, a group of 200 black doctors in Cook County who handle a tremendously large public aid flow.

The material compiled by our organization was to have been presented to the subcommittee on aging. It is a 3-year investigation of fraud and abuse in the Illinois Medicaid program.

Fraud and abuse is not physician-vendor oriented, but rather facilitated by the relationship of the department of public aid and the entrepreneur-owned clinics. The material contained in the three documents—in the three volumes that we have presented to your subcommittee are very pertinent to the consideration of the bill which is up for discussion.

With your permission, Dr. Hutchinson will discuss part one of our statement and I will discuss part two. Then we would be more than happy to answer any questions that you might have concerning the Illinois medicaid program and medicaid at large.

STATEMENT OF CARELL HUTCHINSON, M.D.

Mr. ROGERS. Thank you, Dr. Lagorio. Dr. Hutchinson.

Dr. HUTCHINSON. I am Carell Hutchinson, Jr. I am an orthopedic surgeon practicing in the city of Chicago. I am here representing, as is Dr. Lagorio, a consortium of medical associations of Illinois; specifically, I am also the chairman of the board of trustees of the Cook County Physicians Association in addition to being co-chairman of its political action and information committee.

I am also a member of the board of directors of a group called BILL, the Black Illinois Legislative Lobby which is concerned with legislation affecting the poor in particular and blacks especially. I am also a member of another board which is called the Black Consortium which consists of the black professional organizations in the city of Chicago.

In addition, I have served as a member of the Illinois State Advisory Committee on Public Aid and was appointed by the chairman of that committee in 1974 as investigator of factoring companies.

My brother, serving as coinvestigator of that special appointment, and I spent 4 days in the Illinois Department of Public Aid in Springfield, Ill., and we wrote a report which was submitted to the Illinois State Advisory Committee on Public Aid on August 10, 1974.

In addition, I have served as a member of an ad hoc committee appointed by the president of Illinois State Medical Society, responsive to the board of trustees of that organization.

Dr. Lagorio and I are both members of the appeals committee which serves as peer review committee of the Chicago Medical Society; and I have been a member of the peer review committee since 1970, serving in the capacity of chairman of the insurance mediation subcommittee of that organization for 3 years as well as being a member of the council of the Chicago Medical Society.

The consortium of organizations which we represent not only includes the Cook County Physicians Association, but also the Hispano-American Physicians Association, the Illinois Physicians Union, of which Dr. Lagorio to my right is the president, the Philippine Medical Association of Chicago and the Midwest, and the Prairie State Medical Association of Illinois.

The Cook County Physicians Association and the Prairie State Medical Association both being affiliates of the National Medical Association.

In addition, the Consortium of Black Professional Organizations is also represented in our statement as I mentioned before. It is called the Black Consortium, and the National Christian Leadership Conference, these organizations also having concurred with this statement we are about to present and who also support the presentation.

Mr. Chairman, we welcome this opportunity to appear before you to present the following report on the public aid medicaid situation in the State of Illinois which we feel in terms of the depth and detail that we have presented to you and the documents in these three volumes we have prepared at no small expense and time over the years, we feel that this will be helpful to you insofar as any revisions or indepth information for future reference.

The subject of the chaotic medicaid program in Illinois and recent revelations concerning extensive and pervasive fraud in the program have—this subject has prompted us to respond to this unique opportunity to address you.

Robert and Rosemary Stevens classic work entitled "Welfare Medicine in America: A Case Study of Medicaid" succinctly assesses the important problem areas in the medicaid program. We do not intend to duplicate their statement. However, we would like to take a few comments from them that go to the core of the reasons for the chaotic state of the medicaid program.

One: We are in agreement that medicaid is a vital health program.

Two: We are aware that in 1975, medicaid provided health care for 23 million people in the United States, about 10 percent plus of the population of this country at the time. Also we are aware that medicaid is a huge program; and in 1973, expended $9 billion, $5 billion of which were provided by the Federal Government. By 1976, this price tag had reached approximately $15 billion, and additional supplemental funding will obviously be necessary for many States both in that year as well as in this year.

In the State of Illinois, the price tag has risen to $1.1 billion for 1977, with a possibility of additional supplemental appropriations being required. Thus, this program could well exceed $20 billion or more on an annual basis in the near future.

Three: We agree with the Stevens' conclusion that the medicaid program in many ways represents the most direct involvement with the provision of health care undertaken by the Federal Government and/or the State.

Four: We further agree with their conclusions that the basic faults of medicaid epitomized by lax administration and unanticipated costs were inherent in the legislation and that a more effectively designed program would demand the establishment of clear goals.

Five: We further agree that the promised comprehensive care to the medically indigent has not been realized, thus demonstrating that in practice the program has been a disappointing failure.

Six: We further agree with their conclusion that if the long-term solution for the delivery of health care in this country is to be successful, then its architects should study the welfare experience of public aid Medicaid.

Seven: With the possibility of a national health insurance program in the near future, if the devastating inadequacies of the medicaid program are not solved, it would appear that any comprehensive across-the-board program will be doomed to a similar failure.

Our concerns at the present time are with the numerous problems of alleged fraud in the Illinois medicaid program. Based on our experiences and conversations with other health care vendors in other parts of this country, it is suggested that the Illinois medicaid scandal might be only the tip of the iceberg; and this may well represent a veritable Watergate, nationwide scandal. Our experiences and those of others with whom we have been consulting suggested that the predominant amount of fraud in the medicaid program in Illinois is related to the medical services finance companies so-called medical factoring companies and not to vendor fraud.

It would appear that the consensus of various investigators so far has focused on vendor fraud instead of factoring company fraud and their related sinister associates, which is similar to looking at the doughnut hole rather than the doughnut itself.

In our exhibit—which Dr. Lagorio has upside down—would tend to—this is exhibit 1a. It tends to show in this shaded area what we feel is the predominant form of the fraud in the medicaid program. The press and others have not concentrated on this. They have talked about small vendor fraud.

For those who can't see in the back, we would also like to show it to you.

However, we have another exhibit, our exhibit 1, in which we wanted to point out some of the areas in which we feel this constitutes the real picture of medicaid fraud rather than that talked about and so widely ballyhooed in the press.

We talked about, and many people in the press have alluded to this, the organized crime syndicate. We have corporations, politicians, law firms, and banks and others; and then we have the holding companies. These holding companies own the factoring companies. We find in many instances the factoring companies have overlapping boards of directorship. We have one name associated with 10 of the factoring companies in Illinois, of the 33 that we know about. So this is where the real fraud is. We would also like to show the people seated in this audience the same thing.

We have concentrated here on the doughnut rather than on the doughnut holt.

On the doughnut rather than on the doughnut hole. I hope I said that.

In Illinois, the most that any physician and nationwide allegedly has been paid in the medicaid program during 1 year has been something in the neighborhood allegedly of $790,000. Let's break that down and see what it really means. The individual who supposedly made $790,000 is a member of the Cook County Physicians Association. The billing that was submitted in his name was to a clinic, the Friendship Clinic. The bills were all in his name. The bills were for 50 different physicians working in that clinic, but they were all billed under his name. What comes out in the headlines is this doctor is bilking the program. Somewhere deep deep down in some remote portion of the article that discusses this, they point out this doctor was paid $80,000, a doctor who works—is a very excellent obstetrical-gynecology specialist, and who works 7 days a week in the clinic, and is the executive director of it. There is a huge discrepancy as has been alluded to by other speakers in the reality of where the money goes.

Again, we say this is the doughnut hole, and people are not concentrating on that big doughnut.

Our next exhibit that we will show goes to the heart of that donut. Here is a druggist who is associated with these sinister forces, who is associated with these factoring companies. He says, and brags: "I made $10 million on medicaid clinics in 1 year."

He says in a 10-year period from 1963 through 1973 he has made $100 million. Where are the headlines on this? Where is the massive investigation of the associations of this individual? This is where an indepth investigation is needed in medicaid fraud. We suspect that this is not unique to Illinois, because we are also aware of the Senate Select Committee's various bulletins on medicare and medicaid fraud.

We have talked to them as we have other investigators over the years. It has been our impression that they also agreed with us insofar as the direction of where the predominant fraud in the medicaid program is.

We feel that your legislation does not get to the heart of the matter. It does not get to the nitty-gritty as it were. It deals with small vendor fraud. That is not where the issue is. Even the investigators in Illinois, in my information—that is as current as this past Friday—suggest they are abandoning this approach and trying to get to the factoring firms, the banks, the interlocking banks. They go in one bank to the next bank to the next bank. They can never get to anything because they can't get to the big shots, the real big ripoff artists in the field.

This is where legislation in my opinion should really, really be concentrated. I agree with you that venor fraud—we don't defend it in any way. It should certainly be looked into. We again say this is the doughnut hole and not the doughnut.

The Illinois legislative Advisory Committee on Public Aid cited one pharmacist, as we mentioned, who did the things that we talked about. Needless to say, the problems of the vast amount of fraud would not have developed—and I repeat not have developed—had adequate quality control systems been devised by governmental agencies at the Federal, regional, and/or State levels in Illinois and elsewhere. So the real problem here is with the people who propose the legislation in the first place.

The rise of medical factoring companies parallels increasing monetary appropriations for health care services to the poor under the Medicaid Act.

In Illinois, these moneys began pouring into the State in large quantities by 1969. By 1973, the annual medicaid appropriation had reached $600 million. For 1976, we already stated that it has exceeded $1 billion; and for 1977, $1.1 billion; and with supplementals most likely.

Let's look at the statistics as to where this money has gone.

In 1970, the appropriation was $240,949,895. 1973, that price tag had gone up to $547,577,068. By 1975, that appropriation was $717,551,138.

These net figures do not really get to the heart of the matter. They are the most conservative figures we can possibly gather because they come in the agency itself, the Public Aid Department. They do not even include the supplemental appropriations.

During all of this time, however, the number of patients who have been treated in Illinois have remained fairly constant, from about 980,000 to 1.1 million. And the number of special programs have remained fairly much the same. In 1973, the amount of this monetary outpouring that was paid to physicians was $65,144,830. By 1975, it was $96,140,860. In 1973, the number of M.D. visits was 69,470 per year. By 1975, the number of visits had gone up to 360,169. Let's look at chest x-rays. In 1973, in Illinois, 36,806 chest x-rays were performed; by 1975, it was up to 180,093, an increase of 300 percent in that time period.

Now, obviously, the number of patients had not significantly increased. What has? The monetary outpouring. The biggest ripoff—and I could go into those other statistics about optometrists, dental fillings, about pharmacies. The biggest ripoff was in the area of laboratory services.

In 1973, the price tag was $3,671,738. By 1975, the price tag was $10,466,027. The number of lab tests in 1973, 622,772; and by 1975, they had gone up to 973,860. Whose labs? Where were the labs? We know that in Illinois 10 labs accounted for over 50-some percent of all the moneys paid into them; and these labs were associated with the same sinister forces we are talking about. They were entrepreneur-owned labs. We have the evidence here in these documents to support in some detail with newspaper clippings, with all kinds of court actions and other things that would support these things.

What we are talking about with these facts and figures is obviously a huge ripoff. We say that small vendor fraud could not possibly accommodate this. Even if they tried, they couldn't. The doughnut hole is what has been concentrated on and the doughnut itself has been missed.

It has been frequently suggested by officials in the Illinois Department of Public Aid that its billing payment systems were not structured to handle the large volume of bills which suddenly increased from 100,000 a month to in excess of 1 million and up to 2½ or 3 million per month when medicaid came into being.

This theory denied—it denied—that there was a conscious motive for maintaining an apparently ineffective system to process medicaid bills, but was merely a coincidental development possibly due to the ineffectual department management in particular of one individual in that department.

It is our contention, however, based on extensive investigations by ourselves and verified by others that there is a more plausible explanation; namely, that the Illinois Department of Public Aid billing systems were allowed to remain apparently ineffectual in order to facilitate a massive siphoning off of medicaid moneys; and these were not intended to go to the vendors of one sort or another, but rather to entrepreneurs who were looking to make a big buck.

A detailed report of this investigation was presented to the Illinois State Advisory Committee on Public Aid as I alluded to before on August 10, 1974.

The report was based on an investigation into the Department of Public Aid conducted by myself as investigator and by my brother, Mr. James Hutchinson, acting as coinvestigator for the Illinois State Advisory Committee on Public Aid under direction of Joel Edleman who at the time was the Executive Director of the Department of Public Aid. Exhibit 3 is the body of documents we presented here, the entire report. It is approximately a few pages beyond here. It goes into depth as to what that report showed, the questions we tried to answer, et cetera.

The investigation was conducted in Springfield, Illinois, on July 23 and 24 and July 30 and 31 of 1974. The report suggested that the billing procedures of the Illinois Department of Public Aid facilitated the factoring process; and in our Exhibit 4, we attempted to show an expanded diagram of the structure of the Illinois Department of Public Aid in Springfield insofar as the processing of a public aid bill was concerned. We went into all of their documents. It is the belief of some knowledgeable persons that in spite of significant efforts—we won't go into that first. We will show you this diagram.

We have explained in that document the details about the diagram, because they explain everything that is going on.

In medicine, we learn that the basis of structure is function. The structure of the Department of Public Aid is perfectly structured to facilitate a massive ripoff of money, not by small vendors, but by the forces we talked about before: The sinister forces associated with the medical services finance or so-called factoring companies.

It was kind of difficult to come about the diagram because we had to go through a number of elaborate structures to simplify the whole process.

Mr. Rogers. May I interrupt at this point?

Dr. Hutchinson. Yes, sir.

Mr. Rogers. We do have quite a number of witnesses and the Attorney General will be here at 4 o'clock. We want to get all of the crucial points you are bringing to us which is most helpful.

I do want you to know that the bill would outlaw factoring, which I think is one of the major—as I get from your testimony—one of the major concerns you have, factoring.

Dr. Hutchinson. Yes, sir.

Mr. Rogers. We will outlaw that.

Would you approve of that?

Dr. Hutchinson. By all means I would approve of that. I would go much further than that.

Mr. Rogers. What would you have us do?

Dr. Hutchinson. What I would have you do in addition to outlawing factoring would be to do an in-depth job of investigating where the moneys the factors have acquired have gone and in addition to that to restitute the moneys that have already been siphoned off in that direction and punish the people who have been the guilty culprits here.

Mr. ROGERS. In other words, if we could get prosecutions going, outlaw the factoring, but also try to follow the funds that have already been given?

Dr. HUTCHINSON. Yes, sir.

Mr. ROGERS. And get a restitution and prosecution?

Dr. HUTCHINSON. I would say one other thing. We have found in Illinois the factors have brought up many, many things in the health care delivery system, based upon their ability to manipulate in response to Public Law 92–603, they have been able to manipulate their funds so they now are major owners in all sorts of facilities and functions which medicaid moneys can be paid into. They own funeral homes, nursing homes, moving van companies for the poor. They own medical laboratories. They own many, many facilities or are part owners or subowners of many of these facilities as well as HMO's and other things.

Unless one is able to trace these moneys and restitute them in the State of Illinois, recognizing the political, economic influences in that State, that is the State that Al Capone made, and his influence still, unfortunately, lingers on, many times over in terms of the effectiveness of that influence, it will be impossible for us to have an adequate medicaid program.

I dare say, if you have an NHI the way this thing is set up, you wouldn't have it either. You will be killing or destroying health care delivery in that case. I think the key is getting to the donut, getting to the medical factoring companies.

I should like to now go to my personal notes. I had some other information. I recognize and acknowledge the chairman is correct. We do not wish to monopolize the time. I think there is something very, very personal here. I got into this whole matter because of my personal experience.

Since October of 1969, when I first began my orthopedic surgery practice in Chicago, in the heart of the so-called ghetto, my annual income from the medicaid programs were as follows: In 1969, nothing. We billed relatively small amounts, but it took many months to get anything.

In 1970, I was paid $483. In 1971, I was paid approximately $23,477.58. This was the period in which I was under a contractual relation with a factoring company. Because of the fact that the factoring company did not give us adequate records, we broke with it after only 4 months.

In 1972, my income in the medicaid program was $4,000. This was the period following my severance with the factoring company and a period in which the factors were paid approximately $5,000 from billings submitted directly by me to the State and billings which were not sold to the factoring company.

Here we have an exhibit which illustrates what happened to some of this.

Fortunately, in my office we made a copy of every bill submitted to the State; and not only that, but everything given to the factor, down to the least piece of paper. What we found as a result of my investigation making contacts with the comptroller's office in Springfield and the Attorney General's office, they went through my record in Springfield. We had many investigators working overtime at night to get all the details of my case, of my—what we found were a number of bills which were changed. I would submit a bill for $30 and the bill on record in Springfield would show $50. The same identical bill, if you look at it in depth.

The other change was the mailing office. You can see how somebody made a first generation Xerox copy of my original bill and wrote in the address of the factoring company.

They also changed the office account number at the top.

For those of you in the back, you can look at this.

Mr. Rogers. Has any prosecution occurred as a result of this?

Dr. Hutchinson. When we found this out in 1974 we went to the Attorney General's office in the State of Illinois, we went to the U.S. District Attorney for the State of Illinois. Thus far nothing has been done on a large number of these cases. Not only that, we even asked representatives of the Attorney General's office, would they submit a letter to the State Medical Society or the Chicago Medical Society. We would do the job of collecting this information from the members of those societies.

In other words, what we wanted from them was Xerox and carbon copies of billings submitted by people who were in a contractual relation with a factoring company. From our best information, approximately 4,000 doctors sometime between 1969 and 1974 or 1975 had been in a contractual relation with a factor at some time or other. We felt it would have been helpful to get that information. No letter was forthcoming from the Attorney General or the State Medical Society. We do not know why, but it was not.

We thus see that the vendor fraud frequently is not vendor fraud, but is fraud at other levels.

Mr. Carter. Mr. Chairman?

Mr. Rogers. Did I understand you to say in 1971 when you had a contractual relationship with the factors, that your income went up to $23,000 a year? Is that correct?

Dr. Hutchinson. Very, it went up in the previous year from $483 to $23,470.75.

Mr. Carter. The next year you severed that relationship and your income went down to $4,000?

Dr. Hutchinson. That is correct, sir.

Mr. Carter. How do you account for that?

Dr. Hutchinson. At the time I didn't know. Now I know. It was because the factoring company has a direct line on the payout process in Springfield. It is obvious. We have documents from the press in Chicago dating back to 1973. We have all kinds of newspaper clippings that we have taken out of five or six newspapers which show this relationship.

Mr. Carter. Did they keep patients from coming to you in 1971?

Dr. Hutchinson. The volume of my patients did not decrease. My work did not decrease.

Mr. Carter. But your money did?

Dr. Hutchinson. Yes, sir; from that source.

Dr. Lagorio. Might I add, what this demonstrates is that some force is attempting to drive out the legitimate vendor from the deprived areas so that the entrepreneur can then go in and buy up his clinic, hire foreign doctors at a salary, pay them a salary, and then bill the Illinois Department of Public Aid directly; and at times they work through a factoring company. At other times they don't. We believe that these entrepreneurs are backed up by the factoring companies and that is where the money comes in; and that there is a collusive relationship in these various areas.

Mr. Carter. In fact, they virtually control the medicaid practice in the city of Chicago; isn't that correct?

Dr. Hutchinson. In the entire State of Illinois.

Mr. Carter. In the entire State of Illinois?

Dr. Lagorio. They have gotten so strong that several of the prepaid plans or HMO's that were discussed, our evidence shows were sponsored by factoring money and that they have gotten so powerful that they are going to control the health care delivery system in the inner city in Chicago.

Mr. Carter. Thank you very kindly.

Dr. Hutchinson. Just to finish this portion, in 1973, my total income from the medicaid program was $11,117; 1974, it was $17,057.50; and in 1975, it was $18,000.

Now in 1975, I billed the department for gross billings, probably $125,000. This amount, as I said, was based upon full funding. It was not based upon the 70th percentile. However, if I had been paid at the 70th percentile of usual and customary—on the current basis and not on the basis of the 1963 usual and customary which the State of Illinois uses to make payments—I obviously would have received a substantially greater amount of income than this from that source.

Currently the percentage of my patients who are public aid are approximately 85 percent medicaid or indigent medicare. Part of the reason for the increased percentages in my practice of public aid patients stems from the fact that many hospitals in Chicago in the vicinity of the hospitals where I practice no longer will accept public aid patients. Thus the increased burden is on those of us who are willing to accept such patients and the deficiency in the actual income. Again Dr. Lagoria has stated why this might be: An attempt to drive out those of us who try to do a job of giving quality care to the poor as well as other patients, so they can have a money-making process controlled entirely by them without any quality care or concern. This is what I feel really has to be addressed.

When one considers the fact that the billings that one submits as a legitimate practitioner are frequently rejected, sometimes for no more than a small number being left out in the doctor's AMA identification number, a typo error by the office secretary, and such bills are frequently kept for many months before they are even sent back for corrections even though the official of the department of public aid already knew the name of the particular vendor and could send it back to him, one can see why the costs for such billings are far in excess of the costs for similar billings to private third party carriers where one is neither hassled in the same way, and where the financial remuneration is based upon 80 to 100 percent of usual and customary in most of the policies. This is the reason why people leave this area. This is the reason why many of my friends who have completed residencies at Howard University, where I spent 10 years in training, where they also are not coming to Chicago, when we discuss the economic problems that I have been subjected to since I have been in practice there.

One interesting, and to me somewhat awsome aspect of my personal experience with a factoring company, was this large volume of altered bills filed with the comptroller's office in Springfield, Illinois. These bills were apparently never to have seen the light of day. I was not supposed to make copies of them.

The bills frequently showed increased amounts of money as compared with the bills filed in my office which were sold to the factoring company. In addition, bills which were not even sold to the factoring company were altered frequently for increased amounts of money; the mailing address to which the vouchers were to be sent and the office account number as I have demonstrated before. My office personnel had been told it was not necessary for them to make copies of these bills. I insisted that everything be copied. That is why I have a complete record of these things.

Probably the most complete record in the State of Illinois of any doctor who dealt with a factor.

In addition, the factoring company generated bills on its own receiving payments which normally would have been denied. For example, if I treated a child with a fractured femur, the total amount to me would be less than $450. However, the factoring company received $125 or more for days in the hospital. If I personally billed for such additional funding, I would have been denied such payments.

I think I have stated most of the things that I wanted to state. In summary of this portion of what I want to get at, let me just raise some questions that we feel still have been inadequately answered concerning this: Question number one: Why has it been necessary for physicians or other medicaid vendors in Illinois and elsewhere to hire a factoring company in order to collect legitimate payments in the State?

Number two: How could any State government allow moneys directed by the U.S. Congress to be spent on the delivery of health care services to the needy be directed to entities having nothing to do with the delivery of health care services?

Question number three: How did the factoring companies know when a physician or other medicaid vendor had not been paid by the State medicaid program? We have ample testimony from many, many vendors included in the information we have which show a pattern.

Question Number four: Why did it take the Illinois Department of Public Aid, region five of Health, Education, and Welfare and HEW in Washington, D.C., so many years to stop payments to factors in Illinois when this odious process was known to have been a part of the program as early as 1968, as it was outlawed in New Jersey and a few other places?

Question number five: How much of the total payments allegedly paid to medicaid vendors went thorugh factoring companies on an annual basis in the past 7 or more years, and what actual percentage of these moneys were retained by the factor; and the last question, question number six, who are these factors; and under what statutes have they been regulated both in the State and Federal level in order to obtain Federal funds?

We have evidence in Illinois that they are neither fish nor fowl, that they are not regulated under any statutes. We have evidence that we have given you of the trials of the cases that our researchers have investigated which show that on the one hand when you asked tem, are they finance companies, they say no. On the other hand, if you ask them, are they a collection agency, they say no, they are a finance company. They are not regulated. They are free birds, just flying in the breeze, floating about as they so desire with no restraints on them. We feel this is grossly unfair. If you want regulations, you need more than to say they are outlawed. You need to have detailed indepth investigition.

Mr. CORMAN [presiding]. Dr. Hutchinson, the Chair called to your attention before that we have a great number of witnesses. Your full statement will be in the record.

Dr. HUTCHINSON. I want to say, sir, I appreciate the opportunity of having addressed you.

Mr. CORMAN. Mr. Lagorio.

Dr. LAGORIO. My statement is shorter. In addition to the problems previously discussed in regard to medicaid fraud, medical factoring companies, and fees in the State of Illinois, there are also very large areas of difficulties with the medicaid program in the State which have not been adequately stated by various investigative organizations.

One of the largest complaints at the present time in Illinois by physicians concerns the retrospective audits being conducted by the Illinois department of public aid. These audits are nothing more than witch hunts. That is our fear if PSRO starts doing what you hoped it will do in your bill.

On December 31, 1975 the Illinois department of public aid sent to all physicians rendering care to public aid recipients a blue book entitled "The Medical Assistance Handbook for Physicians". This handbook is the first book of this nature ever published by the department of public aid in Illinois which outlines the rules and regulations by which physicians are to function in rendering care to public aid recipients, and the proper billing procedures to be followed to bill the Illinois department of public aid.

Prior to this book, there were a few rules and regulations on file in the Illinois department of public aid offices which were never disseminated widely to physicians.

The Illinois department of public aid has been conducting a retrospective audit of certain physicians, using rules and regulations which were promulgated at the beginning of 1976, and retrospectively applying these rules to audits of 1974 and 1975 payments. The use of retrospective audits is grossly unfair and quite discriminatory to these physicians. Further, the misapplication of the recently promulgated regulations appear to represent ex-post-facto rules and seem unconstitutional at face value.

The retrospective audits are being conducted by persons who are lacking experience in carrying out medical audits. In addition, these audits are not really focusing on massive fraud. They are concerned with small vendor fraud, or errors. We compliment the department for this concern, though it is 5 years too late. Second, however, it appears that these audits are nothing more than a smoke screen to cover the real and massive fraud which was discussed previously.

In addition, there are significant complaints by Illinois physicians concerning the fact that the Illinois department of public aid has refused to disclose its policies and procedures in determining fee profiles and regulations under which the department functions, in direct violation of Federal guidelines—45 CFR Section 205.70.

Prior to December 31, 1975, the Illinois Physicians Union made numerous requests for copies of manuals, rules and regulations, and procedures used by the department of public aid. These legitimate and reasonable requests have been ignored and denied. We also have statements from various physicians who have requested similar information from the State and have been similarly refused.

Also the State medical advisory committee of the Illinois department of public aid, as presently constituted, does not have the proper representation in that members of consumer groups are not included. The medical advisory committee has not had adequate opportunity for a meaningful participation in the policy development and program administration, including the furtherance of recipient participation in the programs of the agency.

In addition, recently the medical advisory committee has been refusing to allow interested physicians to appear before them to present problems which they have with the program. This can be further documented.

We can go on and on listing areas in which the medicaid program in the State of Illinois is failing to follow Federal guidelines in the implementation of the medicaid program. In the interests of time, we will bring our testimony to a close.

In closing, we wish to state that the chaotic and disastrous situation in which the Illinois department of public aid finds itself at the present time is not based on incompetence, poor management, and the activities of a nonresponsive management structure in the department of public aid. Rather, the chaotic and disastrous situation which exists does so because of a well thought-out process that facilitates the fraudulent activities of the entrepreneurs, who have over the last 7 years become intimately involved in rendering health care to the poor.

In closing, we would once again like to restate that physicians, especially, and most of the health care delivery industry, have been tarnished by the overblown headlines and looking at the hole in the doughnut rather the doughnut itself investigations, which have been thus far conducted. The net effect has been a vast reduction in the number of providers of health care services to the poor, and the crucification of a profession based on the actions of a minute few. The providers of health care services to the poor have been charged with defrauding, and thus making economically unsound the medicaid program. We have been tried in the courts of the media and judged guilty by a misinformed public. We are here on behalf of our members, and other health care providers; but more importantly, we are here on behalf of the needy, for ultimately they are the real victims.

We are here to plead not guilty to the charge, and call as our witness—numbers. Numbers do not lie. Compare the total of all of these providers who have allegedly defrauded the program, with the income of the factors. The comparison would be likened to comparing molehills with mountains.

At this point we would like to reiterate questions which still remain unanswered, and which various governmental agencies should conrern themselves with and answer:

Question 1: Why did a physician have to hire a collection agency to collect funds from the State?

Question 2: How could State government allow moneys directed by the U.S. Congress to be spent on delivery of health care services to the needy, be directed to entities having nothing to do with the delivery of health care services?

Question 3: How do factoring companies know when a physician or other vendor has not been paid?

[The prepared statement follows:]

STATEMENT OF A CONSORTIUM OF MEDICAL ORGANIZATIONS OF ILLINOIS

PART I

This Consortium includes the Cook County Physicians Association, the Hispano-American Physicians Association, the Illinois Physicians Union, the Phillipine Medical Association of Chicago and the Midwest, and the Prairie (State) Medical Association of Illinois. In addition, the consortium of professional Black organizations (Black Consortium) and the National Christian Leadership Conference have also concurred and support this presentation.

INTRODUCTION

Rev. Rogers, Senator Moss and other distinguished members and staff of the Sub-Committee on Health and Environment and the Ways and Means, and other distinguished members of the Sub-Committee on Health, Senate and House of Representative of our Federal Government: We welcome this opportunity to appear before you to present the following report on the Public Aid-Medicaid situation in the State of Illinois.

The subject of the chaotic Medicaid program in Illinois, and recent revelations concerning extensive and pervasive fraud in the program, have prompted up to respond to this unique opportunity to address you.

Robert and Rosemary Stevens' classic work entitled "Welfare medicine in America" (a case study of Medicaid) succinctly assesses the important problem areas in the Medicaid program. We do not intend to duplicate their statement. However, we would like to take a few comments from them that go to the core of the reasons for the chaotic state of the Medicaid program:

1. We are in agreement that Medicaid is a vital health program.
2. We are aware that in 1973, Medicaid provided health care for 23 million people in the United States (10 per cent plus of the population). Also, we are aware that Medicaid is a huge program and in 1973 expended 9 billion dollars (5 billions of which were provided by the Federal government). By 1976, this price tag has reached approximately 15 billion dollars, and additional supplemental funding will be necessary for many states this year. Thus, the program could exceed 20 billion dollars or more on an annual basis in the near future.
3. We agree with the Stevens' conclusion that the Medicaid program in many

way represents the most direct involvement with the provision of Medical Care undertaken by the Federal government and/or the State.

4. We further agree with their conclusions that the basic faults of Medicaid, epitomized by lax administration and unanticipated costs, were inherent in the legislation; and that a more effectively designed program would demand the establishment of clear goals.

5. We further agree that the promised comprehensive care to the medically indigent has not been realized, thus demonstrating that in practice the program has been a disappointing failure.

6. We further agree with their conclusion that if the long term solution for the delivery of health care in this country is to be successful, then its architects should

7. With the possibility of a National Health Insurance Program in the near future, if the devastating inadequacies of the Medicaid program are not solved, it would appear that any comprehensive, across-the-board program will be doomed to a similar failure.

Our concerns, at the present time, are with the numerous problems of alleged fraud in the Illinois Medicaid Program. Based on our experiences and conversations with other health care vendors in other parts of the country, it is suggested that the Illinois Medicaid scandal might be only the tip of the iceberg and this may well represent a veritable "Watergate" nation-wide scandal. Our experiences, and those of others with whom we have been consulting, suggest that the predominant amount of fraud in the Medicaid program in Illinois is related to the medical services finance companies (so-called medical factoring companies).

It would appear that the consensus of various investigators so far has focused on vendor fraud, instead of factoring company fraud, which is similar to looking at the doughnut hole rather than the doughnut itself. (Exhibit I.)

The most that any physician nationwide, has been paid in the Medicaid program during one year has been about $792,000. Yet, some factoring companies are alleged to have profited *over 10 million dollars in one year! ! !* The failure to investigate these latter allegations constitute an oversight difficult, if not impossible, to comprehend.

The Illinois Legislative Advisory Committee on Public Aid cited one pharmacist, with alleged factory company connections, who reputedly bragged that he made over 100 million dollars in a ten year period from various Medicaid schemes. (Exhibit 11.)

In no way do we intend to excuse or support fraud by physicians or any other Medicaid vendors. However, we reiterate our contention that the vast extent of fraud in the Medicaid program in Illinois has resulted because of an organized, collusive, and facilitated conspiracy between officials, and/or personnel employed by the Illinois Department of Public Aid, the Illinois State Government, and some medical factoring companies.

Needless to say, the problems of the vast amount of fraud would not have developed had adequate control systems been devised by governmental agencies at the federal, regional, and/or state levels, in Illinois and elsewhere.

The rise of medical factoring companies paralleled increasing monetary appropriations for health care services to the poor under the Medicaid Act. In Illinois, these monies began pouring into the State in large quantities by 1959. By 1973, the annual Medical appropriation had reached 600 million dollars in Illinois. For 1976, it will exceed one billion dollars. Despite the increasing monetary appropriations, the quality and quantity of health care services available to the poor have continued to deteriorate. The reasons for the continued deterioration can be traced to the billing payment systems used by the Illinois Department of Public Aid.

It has been frequently suggested by officials in the Illinois Department of Public Aid that its billing-payment systems were not structured to handle the large volume of bills which suddenly increased from 100,000 a month to in excess of 1,000,000 a month when Medicaid came into being. This theory denied that there was a conscious motive for maintaining an apparently ineffective system to process Medicaid bills, but was merely a coincidental development, possibility due to ineffectual department management, in particular of one individual in the department. It is our contention, however, based on extensive investigations by ourselves, and verified by others, that there is a more plausible explanation: Namely, that the Illinois Department of Public Aid billing systems were allowed to remain apparently ineffectual in order to facilitate a massive siphoning off of Medicaid monies.

A detailed report of this investigation was presented to the Illinois State Advisory Committee on Public Aid on August 10, 1974. The report was based on an investigation in the Department of Public Aid by Dr. Carell Hutchinson, Jr., and his brother James R. Hutchinson, acting as investigator, and co-investigator, respectively, for the Illinois State Advisory Committee on Public Aid under the direction of Joel Edelman, the then Illinois Department of Public Aid Director (Exhibit III).

The investigation was conducted in Springfield, Illinois on July 23, July 24, July 30 and July 31, 1974. The report suggested that the billing procedures of the Illinois Department of Public Aid facilitated the factoring process. (Exhibit IV: Expanded Diagram of the Structure of the Illinois Department of Public Aid in Springfield).

It is the belief of some knowledgeable persons that, in spite of significant efforts, it may be already too late to stop the factoring companies from continuing to fraudulently exploit the Medicaid program. While it is quite true that Federal Regulations (under PL 92–603, Section 236B) have now forbidden vendor payments to factoring companies, the truth is that the factors have now, in fact, become full-fledged medical vendors. They own numerous health care facilities throughout the spectrum of activities for which Medicaid payments can be made, including medical clinics, nursing homes, funeral homes, ambulance and moving van companies, pharmacies, medical laboratories, etc. There are suggestions that they have acquired extensive holdings in the HMO structure. They have been paid preferentially, often-times far in excess of what an ordinary medical vendor would be paid providing a similar service. Monies already paid them in vast quantities from the Illinois Medicaid funds have apparently facilitated, according to some authorities, their diversification by providing them with the necessary capital to purchase various facilities.

According to some investigators, the machinery allowing this massive siphoning off of Medicaid funds in Illinois has been well oiled by "greenbacks" all along the process. The implications are obvious when supervisory officials, paid $16,000 to $24,000 annually, are in charge of administering programs expending approximately two billion dollars annually. Further, some investigators suggested the possibility that many vendor groups and watchdog organizations, having direct responsibility for preventing fraud in the Medicaid program, have been possibly compromised. It would seem appropriate, that all officials, both administrative and professional, in vendor groups through which Medicaid monies can be paid, should be required to sign affidavits to the effect that they are not involved in any conflicts of interest in this area.

We submit that the slow, low and/or no payment practices of the Illinois Department of Public Aid have been largely responsible for driving legitimate health care vendors away from the Medicaid program. This has encouraged exploitation of Medicaid patients, in many instances by fly-by-night entrepeneur-owned Medicaid clinics. Many examples of these allegations can be cited.

In Illinois, numerous medical vendors are being sued by factoring companies for alleged indebtedness. We have found that some factoring companies' contractural charges are similar to the odious "juice" rackets conducted by crime, and outlawed some years ago, in Illinois.

It would seem most appropriate for the Federal government to investigate these cases, inasmuch as the problem was created by the lack of governmental quality control provisions in the Medicaid program. The government has direct responsibility for the additional costs to providers in having to finance these legal suits and should legitimately assume these financial burdens.

The level of payments in the Medicaid program in Illinois are inadequate for legitimate vendors. Elimination of fraud in the Medicaid program could result in increased payments to legitimate vendors without additional budgetary appropriations. The magnitude of fraud in Illinois has been estimated conservatively to represent as much as 50 cents out of every dollar or as much as 500 million dollars out of the current annual 1 billion dollars Medicaid appropriation. The official HEW 600 million dollars nationwide fraud figure would, therefore, seem to be grossly underestimated, if the Illinois estimate are correct, and 500 million dollars is being siphoned off in the State of Illinois alone. The more probable figure should approximate, nationwide, as much as one-quarter to one-half of the annual Medicaid appropriation representing a figure of between four to eight billion dollars annually!!!

Small, independent vendor fraud could not possibly approach this magnitude of fraud. A well-integrated and carefully planned and implemented scheme of fraud would more probably be necessary to achieve this level of fraud. Factoring companies, in cooperation with officials of various State governments and the Illinois Department of Public Aid, however, *are* capable of perpetrating such levels of fraud.

We have not been impressed with the manner in which various governmental agencies charged with the responsibility of ferreting out fraud in the Medicaid program have approached this problem. Thus far, it would appear that they are reluctant and/or afraid to go after the real culprits mainly responsible for fraud in the Illinois Medicaid program.

For example, governmental investigative agencies in Illinois proceeded with vigor, and resultant newspaper headlines, indicating intentions to prosecute and indict eight welfare mothers for allegedly cheating the state out of a total of $25,000.00. Yet, some of these same governmental agencies have refused to follow leads or proceed with various investigations of fraud perpertained by medical factoring companies, even when information was given to them.

As a result of irrefutable evidence of factoring companies altering bills submitted by physicians, our organizations requested that the Attorney General of the State of Illinois submit a written request to the Illinois State Medical Society and the Chicago Medical Society to poll their members for further evidence, in the form of xeroxed copies and/or carbon copies, of bills submitted to factoring companies, to be used for comparison with bills received and on file in the Illinois Comptroller's office and paid by the Illinois Department of Public Aid. No such request has yet been made, as of this date.

Investigative reports alleging to accurately reflect a factual picture of the Medicaid situation in the State of Illinois and the Department of Public Aid have been disappointing insofar as the conclusions reached did not appear to reflect objective reality. This further suggests to us, in light of subsequent developments, that further investigations would most probably be fruitful. Perhaps these and other leads will be pursued now that the 1976 national elections are over.

On a personal note: since 1967, the cost of living in the United States—and certainly in the metropolitan areas of Illinois and elsewhere—has increased, according to some authorities, asmuch as 100 per cent. Yet, the increase in physician payments in the Medicaid Program in Illinois has not kept pace with these economic realities. Indeed, this is a highly understated statement. The politics and economics of medicine in Illinois, and our country, in general, however, have not been fundamentally altered. Despite some very admirable governmental and private programs attempting to compensate for the inadequacies of the past, blacks and other so called minority group citizens are still the first fired and the last hired. The statistics for black unemployment in this country, and certainly in the city of Chicago where my practice is located, dismally reflects this reality. In my opinion, governmental statistics concerning unemployment in the United States, do not reflect the profound depth of social and economic difficulties of the unemployed, coupled with the under-employed. In some of our communities for example, black male youth unemployment exceeds 70 per cent of the total potental working population. It is not uncommon to travel in the metropolitan areas of cities across this country, and find black adult males standing around with no jobs, and no prospects for any.

Thus, those of us who attempt to provide health care services for this indigent population—and I am not talking about the charlatans and the "rip-off artists"—are asked to pay an extremely high price for the "privilege" of practicing in these economically depressed areas. Indeed, we are actually taxed at a level far in excess of the stated taxes. Each time we treat a Medicaid patient—and receive the run around—in the forms of low, slow and/or no payment—we are paying an extra tax. Even when we are compensated at the seventieth percentile of what is supposed to be usual and customary—and in Illinois the usual and customary for a physician has been based on the 1963 Illinois Relative Value Study, with payments reflecting the 1963 standards—we are paying an extra and very significant tax.

The irony is that tax collecting governmental agencies require us to pay our numerous taxes just as everyone else. And if the percentages of Medicaid patients in our practices approach thirty to ninety percent or higher, we are in very serious economic jeopardy. We can't meet our bills and personal obligations. Not unless we affiliate with a factoring process—or possess political clout. This has been the experience of the overwhelming number of doctors and other Medicaid vendors known to me.

The "Sixty Minutes" TV programs alleging to present an objective and thorough analysis of the Medicaid fraud situation, have, in our experience, done a grave injustice to giving an honest, thorough-going analysis of the true situation.

The doctors and other vendors receiving high incomes from the Medicaid Program—but without being "ripped-off" by the factoring companies, and/or possessing political clout—are the exception, rather than the rule. I'll give you a personal example of what I mean.

Since October, 1969, when I first began my orthopedic surgery practice in Chicago, my annual incomes from the Medicaid Programs were as follows:

1969—nothing.

1970—$483.00.

1971—approximately $23,407.75 (this was the period in which I was in a contractual relationship with a factoring company).

1972—$4,000.00 (this was the period following my severance with the factoring company and a period in which the factors were paid approximately $5,000.00 from billings submitted directly by me to the State, and billings which were not sold to the factoring company).

1973—$11,117.00.

1974—$17,057.50.

1975—$18,000.00.

1976—$30,919.50 (to date of this writing).

It is important that I note here the periods in which I received the maximum returns from the Medicaid Program were: 1971—when I was affiliated with a factoring firm, and in 1976 and the latter part of 1975, after I had contacted some of my friends who are elected members of the Illinois State Legislature. Because of the inadequacies of the payments to me, at a time when forty to eighty per cent of my patients were Medicaid and/or needy Medicare patients, and because of the deficient levels of return. I contacted these friends in the Legislature. They, in turn, contacted an influential official in the executive branch of State Government. Thus, the increase in the out-pouring of monies due me based on my billings to the Illinois Department of Public Aid. Some of the payments included bills submitted as early as 1971.

I might add that in 1975, my total billings to the Illinois Department of Public Aid were $125,000.00. This amount was based upon full funding. It was not based up on the seventieth percentile. However, if I had been paid at the seventieth percentile of usual and customary, on the basis of current usual and customary, I should certainly have received far in excess of $18,000.00 I received in 1975. At that time, the percentage of my patients whe were Public Aid varied from sixty-seven percent in the early part of the year, to approximately eighty-five percent in the latter part of the year. Currently, the percentage of my patients who are Public Aid are approximately eighty-five per cent. Part of the reason for the increased percentages in my practice of Public Aid patients stems from the fact that many hospitals in Chicago, in the vicinity of the hospitals where I practice, no longer will accept Public Aid patients. Thus, the increased burden on those of us who are willing to accept such patients, but the deficiency in the actual income.

When one considers the fact that the billings are frequently rejected, sometimes for no more than a small number being left out in the doctor's identification number, and such bills are frequently kept for many months before they are even sent back for corrections, even though the officials know the name of the particular vendor, one can see why the cost for such billings are far in excess of the cost for similar billings to private third party carriers where one is neither hassled, and where the financial remuneration is based upon eighty to one hundred percent of usual and customary.

One interesting, and to me somewhat awesome, aspect of my personal experience with a factoring company was the large volume of altered bills on file in the Illinois Comptroller's Office in Springfield, Illinois. These bills apparently were never to have seen the light of day. Certainly, I was never to have seen them. The bills invariably showed increased amounts of money, as compared with the bills on file in my office which were sold to the factoring company. In addition, bills which were not even sold to the factoring company were altered, frequently for increased amounts of charges, the mailing address to which the vouchers were to be sent, and in the office account number.

My office personnel had been told that it was not necessary for my office to make copies of the bills that we gave to the factoring company. However, my office personnel were instructed by me to make copies of every piece of paper given to the factoring company. The factoring company personnel were also told that we wanted copies of every re-cap sheet, every voucher, and any other correspondence between the factoring company and the Illinois Department of Public Aid on my behalf.

Because the latter stipulations were not complied with, after four months, I decided to sever my contracual relationships with the factoring company. This was based upon their inefficient administrative procedures, more so than any suspicion on my part, at that time, that their procedures were fraudulent.

In addition, the factoring company generated bills on its own, receiving payments which I nomally would have been denied. For example, if I treated a child for a fractured femur as a result of being struck by a car, the total payment for me would normally be less than $450.00. However, the factoring company generated an additional bill, based upon the days the patient was in the hospital, and in several instances, received $125.00 or more simply for the days in the hospital. If I personally had billed for such additonal funding, I would have been denied such payments.

Fortunately, I was able to get copies of bills filed in Springfield, primarily as a result of the fact that I had been appointed the investigator of possible factoring company fraud and while I served as a member of the Illinois State Advisory Committee on Public Aid. I was astonished when I compared the bills on file in Springfield with the bills originally sent out by my office.

For example, if I had originally submitted a bill for say $20.00, the bill on file in Springfield might show $55.00 or $45.00. No attempt was made to even make a sophisticated alteration in the billing. I had never been informed of the fact that the factoring company had made such alterations of my bills. I certainly would not have sanctioned such changes had I known about them. Furthermore, I personally did not profit from the increased amounts billed in this fashion.

When I informed other vendors of my acquaintance of my personal experience, they were similarly surprised. When one such physician who still had a contractual relation with the same factoring company that I had been with, asked this company representative if any of this physician's bills had been altered, this physician was informed that bills had been altered by the factor, allegedly, in order to obtain more money for the doctor. However, this MD, like myself, had no prior knowledge of these altered bills. Or the extent to which billing alterations had been made.

I submit that much of the alleged vendor fraud has been perpetrated by the factoring companies, and facilities associated with some of these factoring companies, and preferential payments having been virtually guaranteed because of the collusive, facilitated relationship with officials in the Department of Public Aid and in State Government.

We repeat for the "nth" time what we stated publicly since this matter was presented by me at an open hearing before the Illinois State Advisory Committee on Public Aid, on May 29, 1974, in Springfield, Illinois:

"The overwhelming amount of fraud in the Illinois Medicaid Program appears to be a practical and logical consequence of the collusive relationship betaween factoring companies, officials of the Illinois Department of Public Aid, and other governmental officials associated with state government.

An individual vendor may in fact, be a crook. But some of the factors, some Illinois Department of Public Aid and other government employees and officials, appear to be Master crooks. We further submit that whereas an individual Medicaid vendor may "rip-off" the Medicaid Program, the Master "rip-off" artists, considering the magnitude of the fraud, appear to be the combination of some Illinois governmental officials, some personnel employed in the Illinois Department of Public Aid, and in combination and collusion with some factoring firms and/or facilities in part or in whole owned by them.

Who are these specific individuals in these factoring companies and/or facilities owned by them? We do not claim to possess this specific information, in any depth or detail. However, ascertaining who these individuals are, would seem quite logically the solemn obligation and responsibility of governmental officials charged with the duty of overseeing this process.

In fact, unless the Master criminals, at all levels, responsible for the massive "rip-off" of Medicaid funds are identified and brought to justice, and the misappropriated funds restituted, those of us now aware of what has transpired can have no genuine confidence in the validity and credibility of the investigative procedures so widely publicized in the media.

Questions which, in our opinion, still remain either inadequately answered, or unanswered, and which various governmental bodies should supply the answers to, include the following:

Question 1. Why has it been necessary for physicians or other Medicaid vendors in Illinois, and elsewhere, to hire a factoring company in order to collect legitimate payments from the State?

Question 2. How could any State Government allow monies directed by the U.S. Congress, to be spent on the delivery of health care services to the needy, be directed to entities having nothing to do with the delivery of health care services?

Question 3. How did the factoring companies know when a physician or other Medicaid vendor had not been paid by the State Medicaid program?

Queston 4. Why did it take the Illinois Departmtnt of Public Aid, Region #5 of Health, Education and Welfart and HEW in Washington, D. C., so many years to stop payments to factors in Illinois?

Question 5. How much of the total payments allegedly paid to Medicaid vendors went through factoring companies on an annual basis over the past seven or more years and what actual percentage of these monies were retained by the factors?

Question 6. Who are these factors, and under what statutes have they been regulated in order to obtain federal funds?

Until and unless the prtvious six questions, at least, have been definitely answered, and the public informed of these answers, truthfully and in depth, there can be no really objective and fair assessment of the Medicaid fraud issue.

We have been told that the answers to some of these questions, in Illinois, can be found by simply isolating all bills paid to each factoring company over the years. This information should be available as a part of the computers memory banks. The isolated bills could then direct investigators to the voucher numbers. The cancelled warrant should then reveal which bank and in whose bank account the cancelled warrants or checks were deposited. This could be followed by audits determining if the income of the factors as stated in their tax filings and in their books, were consistent with the data on file in the state government offices.

It is somewhat inconceivable to us after looking over the broad expanse of the investigations thus far, why this obviously logical investigation has not been done—any why, if it has been done, the information not turned over to the public, to present a fair assessment of the Medicaid fraud situation.

The successful resolution of these problems will determine whether or not the Medicaid program, including the Illinois program, will survive, and the delivery of health care services to the poor raised to a level commensurate with quality health care, and the vast sums of taxpayers money expended in this effort.

PART II

In addition to the problems previously discussed in regard to Medicaid fraud, medical factoring companies, and fees in the State of Illinois, there are also very large areas of difficulties with the Medicaid program in the State which have not been adequately stated by various investigative organizations.

One of the largest complaints, at the present time in Illinois, by physicians, concerns the retrospective audits being conducted by the Illinois Department of Public Aid.

On December 31, 1975, the Illinois Department of Public Aid sent to all physicians rendering care to public aid recipients a Blue Book entitled "The Medical Assistance Handbook for Physicians".

This Handbook is the first book of this nature ever published by the Department of Public Aid in Illinois which outlines the rules and regulations by which physicians are to function in rendering care to public aid recipients, and the proper billing procedures to be followed to bill the Illnois Department of Public Aid.

Prior to this book, there were a few rules and regulations on file in the Illinois Department of Public Aid offices which were never disseminated widely to physicians.

The Illinois Department of Public Aid has been conducting a retrospective audit of certain physicians, using rules and regulations which were promulgated at the beginning of 1976, and retrospectively applying these rules to audits of 1974 and 1975 payments. The use of retrospective audits is grossly unfair and quite discriminatiry to these physicians. Further, the misapplication of the recently promulgated regulations appear to represent ex-post-facto rules and seem unconstitutional at face value. The retrospective audits are being conducted by persons who are lacking experience in carrying out medical audits. In addition, these audits are not really focusing on massive fraud. They are concerned with small vendor fraud, or errors. We compliment the department for this concern, though it is five years too late. Secondly, however, it appears that these audits are nothing more than a "smoke screen" to cover the real and massive fraud which was discussed previously.

In addition, there are significant complaints by Illinois physicians concerning the fact that the Illinois Department of Public Aid has refused to disclose its policies and procedures in determining fee profiles and regulations under which the department functions, in direct violation of Federal guidelines. (45 CFR Secton 205.70)

Prior to December 31, 1975, the Illinois Physicians Union made numerous requests for copies of manuals, rules and regulations, and procedures used by the Department of Public Aid. These legitimate and reasonable requests had been ignored and denied. We also have statements from various physicians who have requested similar information from the state and have been similarly refused.

Also the State Medical Advisory Committee of the Illinois Department of Public Aid, as presently constituted, does not have the proper representation in that members of consumer groups are not included. The Medical Advisory Committee has not had adequate opportunity for a meaningful participation in the policy development and program administration, including the furtherance of recipient participation in the programs of the agency.

In addition, recently the Medical Advisory Committee has been refusing to allow interested physicians to appear before them to present problems which they have with the program. This can be further documented.

We can go on and on listing areas in which the Medicaid program in the State of Illinois is failing to follow Federal guidelines in the implementation of the Medicaid program. Further, we can also list numerous other areas where vendor participation is discouraged because of the rules and regulations under which the program functions, which allows very little input from vendor groups.

The report by the Comptroller General of the United States to the Sub-Committee on Health, Committee on Finances, of the United States Senate, presented on April 14, 1975, stated that:

1. An increased effort was needed to detect Medicaid fraud and abuse in Illinois.
2. Improvements were needed in the Illinois system for paying the Medicaid program.
3. The need to improve the system for reviewing the use of Medicaid services.

These requirements were never enforced by Federal HEW.

Finally, in closing we would like to make the following statement: in our dealings with physicians who render care to public aid recipients in the deprived areas of the State of Illinois, it is our feeling that most of these physicians are very honest and honorable men and women, who have on occasion been driven to the brink of bankruptcy by the devious procedures used by the Illinois Department of Public Aid.

As mentioned previously, the major portion of fraud that exists in the Medicaid program in the State of Illinois appears to be perpetrated by the entrepreneur and factor-owned facilities, who hire physicians and bill the Illinois Department of Public Aid in their name, often, on a much higher rate of reimbursement than paid the physician-employee.

The legitimate physicians who stayed in the deprived areas rendering care to public aid recipients should be looked upon as the true missionary physicians of our day, because they are staying in areas where quality medical care without them would be unavailable. They are working for reimbursements at levels 50 perc ent or less than that of the private practicing physician in other areas. They are also risking bodily harm because of the nature of the areas in which they practice. These physicians should be held up as examples of what the true physician is and they should be commended for their zeal to their patients in being available to treat them for their ills.

In conclusion, we wish to state that the chaotic and disastrous situation in which the Illinois Department of Public Aid finds itself at the present time, is not based on incompetence, poor management, and the activities of a non-responsive management structure in the Department of Public Aid. Rather, the chaotic and disastrous situation which exists does so because of a well thought-out process that facilitates the fraudulent activities of the entrepreneurs, who have, over the last seven years, become intimately involved in rendering health care to the poor.

The facilitation for the fraudulent activities of these groups is either directly or indirectly tied in with the management procedures which have been fostered by the policies of the managerial staff of the Illinois Department of Public Aid.

The evidence tends to indicate that this facilitation for fraud is directly tied in with the way the Illinois Department of Public Aid was allowed to function until January of this year. As months go by, and more and more evidence accumulates and is presented, we predict that the statements that have been made here today will be further brought to light and will expose these relationships.

In closing, we would once again like to restate that physicians, especially, and most of the health care delivery industry, have been tarnished by the overblown headlines and the "looking at the hole in the doughnut rather than the doughnut itself" investigations, which have been thus far conducted. The net effect has been a vast reduction in the number of providers of health care services to the poor, and the crucification of a profession based on the actions of a minute few. The providers of health care services to the poor have been charged with defrauding, and thus making economically unsound the Medicaid program. We have been tried in the courts of the media and judged guilty by a misinformed public. We are here on behalf of our members, and other health care providers, but more importantly, we are here on behalf of the needy, for ultimately they are the real victims. We are here to plead "not guilty" to the charge and call as our only witness———Numbers. Numbers do not lie. Compare the total of all of these providers who have allegedly defrauded the program, with the income of the factors. The comparison would be likened unto comparing molehills with mountains.

At this point, we would like to reiterate questions which still remain unanswered, and which various governmental agencies should concern themselves with an answer:

Question 1. Why did a physician have to hire a collection agency to collect funds from the state?

Question 2. How could state government allow monies directed by the United States Congress to be spent on delivery of health care services to the needy, be directed to entities having nothing to do with delivery of health care services?

Question 3. How do factoring companies know when a physician or other vendor has not been paid?

Question 4. Why did it take Region 5 of HEW so many years to stop payments to factors in Illinois?

Question 5. How much of the Medicaid payments went to the factors on an annual basis?

Question 6. Who are these factors?

We commend and also affirm our commitment to the recommendation made by the staff report of Subcommittee on Aging of August 1976 concerning fraud and abuse among medical practitioners, part 7, pages 222–226. We need not repeat those recommendations here. However these recommendations, in our opinion, constitute the basis for the elimination of fraud in the Medicaid program.

In addition, we strongly urge the United States Congress, as well as other investigative bodies, to conduct an in-depth analysis of the true extent of the abuse and fraud in the Medicaid program perpetrated by the factoring process. Hopefully a similar staff report covering this aspect of fraud will be forthcoming.

Once again, we wish to thank you for the opportunity of appearing before you and would be more than happy to discuss any of the documents which we have presented to substantiate our claims and to answer any questions that you might have. Thank you.

Mr. CORMAN. Doctor, I believe these questions were read into the record.

Dr. LAGORIO. Once again we thank you for the opportunity of being able to appear.

Mr. CORMAN. Mr. Pike?

Mr. PIKE. No questions.

Mr. CORMAN. Mr. Duncan?

Mr. DUNCAN. No questions.

Mr. CORMAN. Thank you very much for your contribution to the hearings. We appreciate it.

Mr. ROGERS [presiding]. May I ask one question?

We will go over your findings. We will also make inquiries as to why nothing was done on this information. Would you make a note of, to see why nothing was ever done? If you have additional information, we hope you would keep in touch with the committee to let us know. We will try to follow up some.

Dr. HUTCHINSON. We would like that very much.

Mr. ROGERS. Has this been furnished to the Department of HEW?

Dr. LAGORIO. We will tomorrow.

Mr. ROGERS. Will you give that to the Department asking that they——

Dr. HUTCHINSON. We met back in March of last year with regional HEW officials. We gave them a very huge stack of material that we had. Supposedly this information was conveyed to Washington and had influence on their setting up a large team. They increased the number of investigators to 105.

Mr. ROGERS. I wanted to be sure they have this. It wouldn't hurt to give them another copy over there. They set up the Office of Inspector General, you know. I think it would be well to do that.

Doctor, let me ask you this: It seems to me we could get a great deal of information from the members of your group as to what we ought to do to stop some of this abuse and fraud. It is more difficult to stop abuse, I think, than maybe fraud.

I would welcome any specific suggestions as to provisions of law or administrative provisions that you think ought to be checked into or investigative activities.

Dr. HUTCHINSON. May I make one suggestion, sir?

Mr. ROGERS. Certainly.

Dr. Hutchinson. According to investigators who have been working in this area a long time, they say the most important thing that needs to be done is that a State like Illinois needs to have the computer capability of doing not retrospective but prospective detection of fraud. Texas apparently is a very excellent State where there is minimal abuse in their program. They are able to take both vendor fraud as well as recipient fraud and to anticipate it on the basis of some irregularity. We have a case that I could present to you showing one person in the course of 1 year personally causing the department of public aid to spend over $5,122, and was never hospitalized, by having 162 M.D. visits and had over 600 prescriptions filled. It was an addict who—half the prescriptions were sold to somebody else for profit for him.

In Texas this couldn't occur, because anybody who was outside the norm, the computers can very quickly pick it up. We have been told by the directors of the department of public aid it is not their responsibility to do prospective determinations of fraud. We feel that this is stupid, that you can detect this right away and you can get anybody before they have bilked the State for millions of dollars.

Mr. Rogers. We will also inquire into that and see why that can't be done.

Dr. Lagorio. Mr. Chairman, if I may, one last remark to what Dr. Hutchinson says.

The only way you are going to clear medicaid in Illinois is to take the medicaid program away from the Illinois Department of Public Aid and put it with an organization that is going to have accountability such as a third party payor, or the Illinois Foundation for Medical Care, someone who, when you raise a question, they will have to get an answer or you take away the contract.

The people in the department are so entrenched now that the factoring process and its ripoff will continue to go on, no matter who is at the administrative level.

Mr. Rogers. We are going to make unlawful the factoring within this bill if it passes. I hope we will stop that.

Dr. Hutchinson. What we said before, sir, is that the State of Illinois will not be stopped by that process alone. The only way to stop the process, because as I see it the factoring is simply a form. When you compare form and substance, the substantive aspects of it are that they have the money. When you have the money, you find another means of achieving the same ends. Unless you retrieve the money that has already been expended and prosecute those responsible for that massive fraudulent collusive relationship which has developed in Illinois—perhaps it's elsewhere—then you will not really clean up the process.

Mr. Rogers. We will try and see what can be done to clean it up. We appreciate the testimony all of you have given. It has been helpful.

Were there any questions?

Dr. Asimus. I might mention one thing: The interns and residents are prepared to work with your committees and inspector general.

There is one concern that we have, and that is that we are employees. We can be hired and fired and not given contracts for our residencies next year. We are asking for protection as well as in our training programs. Some of that we have through collective bargaining and due process there.

As you know, though, the National Labor Relations Board referred to us as students last year. In the private sector we are excluded from collective bargaining. That puts the fear of God in the residents to speak up. They have no protection and have been eliminated from residency programs for being courageous and speaking up about abuses.

We are also sharing a problem we have with your committee.

Mr. Rogers. If you have any examples where there have been persons speaking up and they have been denied due process of their rights in comparison to the others, let us know.

Dr. Asimus. Thank you.

Mr. Rogers. We will make an investigation and see what can be done.

Thank you for your presence here.

The next panel will be Dr. Anthony Robbins, who is the chairperson, Action Board of the American Public Health Association, and President; and President Peter Terenzio, Dr. Kresky, and Dr. Gary Eidsvold, of the New York City Public Health Association.

A PANEL CONSISTING OF ANTHONY ROBBINS, M.D., CHAIRPERSON, ACTION BOARD, AMERICAN PUBLIC HEALTH ASSOCIATION; AND PETER TERENZIO, PRESIDENT, BEATRICE KRESKY, M.D., CHAIRMAN, POLICY AND LEGISLATION COMMITTEE, AND GARY EIDSVOLD, M.D., GOVERNING COUNCIL DELEGATE, NEW YORK CITY PUBLIC HEALTH ASSOCIATION

STATEMENT OF ANTHONY ROBBINS, M.D.

Dr. Robbins. I am Dr. Anthony Robbins, chairman of the American Public Health Association.

Mr. Terenzio. I am Peter Terenzio. This is Gary Eidsvold. Dr. Eidsvold is a public health official and is intimately acquainted with the situation in the Bronx.

Mr. Rogers. Thank you. We welcome each of you.

Dr. Robbins. Mr. Chairman, I realize we are pressed for time. I appreciate the opportunity to make our presentation to you. I will try to—I will try to summarize the presentation.

Mr. Rogers. That would be helpful.

Dr. Robbins. I think the first point that is worth making is that there is a distinct difference between fraud and abuse. As you approach this problem, I call your attention to the fact that fraud is a legal problem and can be dealt with through investigation and legal procedures; but abuse is due at least in part or exists in part because of poor program management in medicare and medicaid; and the solutions we would suggest are available mostly through management approaches.

This is clearly not simply a problem in the public sector but more generally in medical care in the United States. It is our belief that the creation of a strong unified data system that speaks to utilization statistics, that speaks to a uniform chart of accounts, that speaks to accounting for assets and ownership and deals with all providers who operate under medicare and medicaid would be a very important step toward dealing with this problem. In fact, if you move in that direction, we would urge you to make that kind of information once it is accumulated available to State government, to State planning agencies, to health systems agencies, because this becomes more than just a medicaid and medicare management problem.

Let me comment briefly on the issue of assignment or factoring.

We are supportive of the way you are going in eliminating that practice; but we want you to know that we think there probably are some real problems which have caused physicians and others to rely on assignment in order to get their bills paid; and again we hope you will look toward the management systems which are not now paying the bills quickly enough and therefore encouraging this kind of thing.

Mr. Rogers. Yes. I am sure that is the major factor bringing this about.

Dr. Robbins. We think your section on the disclosure of ownership and financial information is terrific.

Two minor suggestions, I think, are worth mentioning. First of all, the information that you acquire under that section ought to be available to appropriate State agencies as well as to the Federal Government; and we have proposed specific language that would deal with that. Secondly, under the same area we think there is probably also a problem where members of medical staff have ownership interests and that this is something that ought to be disclosed beyond the requirements that are currently in the bill; and we have suggested language that would deal with that.

Under the issue of shared health facilities, we think it is a good idea. We think that you have tried to develop language that distinguishes between the bad guys and the good guys; but we are a little bit worried that it may not work and would hope that you would include in the final language of the bill something that suggests that the Secretary ought to look at it after 3 or 4 years and decide whether, in fact, this—these kinds of—control of this kind of definition is working.

The penalty issue is one again where we are supportive of the legislation. A small suggestion, something that we do routinely now in Colorado for our nursing home and hospital inspection programs is that wherever you pick up a violation that relates to an individual who is licensed by a State licensing board, the information about the violation ought to be required to be communicated to that body.

Mr. Rogers. To the licensing board?

Dr. Robbins. To the licensing board for nursing home administrators, pharmacists, and the like.

Mr. Rogers. Yes.

Dr. Robbins. You have dealt with the area of professional standards review organizations; and I guess the question that we have in view of the current literature is, are professional standard review organizations doing any good; do they work? We are a little bit worried. I think we are quite worried about giving them more responsibility when it is not at all clear that they are achieving the ends for which they were intended.

More specifically, in the area of decisionmaking, we are worried about giving the decisionmaking power to the professional standard review organizations in a manner that does not allow State government, medicaid agencies, for example, to decide after the advice whether or not to pay the bill.

That is one of the concerns. We think that giving the PSRO's a responsibility in the area of shared health facilities may be unwise because they have little or no experience at the present time with the evaluation of ambulatory care; and it may be more useful at this time to develop the information systems so that the existing medicaid and medicare agencies can accomplish the same goals through better program review.

In the area of data, we are supportive of what you are doing, but would urge that the language be clarified in a way that it is clear that PSRO's will not unilaterally develop their own data systems but will take advantage of existing systems or systems developed cooperatively; and in the area of information transfer. the language refers to discretion in information sharing. We might prefer the word, the term "initiation" because we do not believe that it should be left solely to the PSRO's to decide which information should be shared.

To summarize for you, back in 1974, the Association adopted a resolution which expressed its concern over the lack of data about the interrelationships among various control incentives such as PSRO, health maintenance organizations, utilization review, provider standards, and capital expenditure control.

We still believe that these methods have not been sufficiently proven in their effectiveness either independently or in combination.

We are encouraged by the hearings today bringing together the two committees of Congress which deal with these subjects and hope that out of it some kind of integration and rationality will evolve.

While the thrust of our remarks have suggested the need to strengthen the data management systems of existing program such as medicare and medicaid, the longer range concern must be with the mechanism by which the public sector provides controls and incentives for improved performance of the private sector responsible for the delivery of health services.

Thank you.

[The prepared statements follows:]

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION PRESENTED BY ANTHONY ROBBINS, M.D., CHAIRPERSON, APHA ACTION BOARD

The American Public Health Association (APHA) is the nation's foremost multi-disciplinary professional society representing 50,000 health professionals, including 51 state and local affiliated organizations. The Association commends Congressman Rostenkowski and Congressman Rogers for the effort and consideration which have gone into developing H.R. 3, and is pleased to have the opportuity today to present our comments on the proposed Medicare-Medicaid Anti-Fraud and Abuse Amendments.

This Association agrees that there are great problems with respect to fraud and abuse. It is difficult to even estimate the scope, the extent, and the effects of these problems. Estimates of the effects vary from millions to hundreds of millions of dollars. It must be remembered, however, that the terms fraud and abuse wnile often felt to be synonymous, are two very different concepts requiring different control mechanisms.

Fraud is a legal concept and its investigation and prosecution requires special investigatory and legal skills. Abuse, on the other hand, exists because of poor program management and poor program design, and its identification, investigation, and control should remain with those who are accountable for managing the programs.

The problems of fraud and abuse exist not just in public programs, but in the delivery system generally and in the incentives that are used in the delivery system. In order to ferret out these problems in a public program, we must decide if we are willing to spend more money than it may be worth to spend. If we have thousands of investigators in the HEW Office of the Inspector General, as many or twice as many at the state level, and PSRO's at the local level, it will be like calling on a division of artillery to kill a few nasty flies. When we have more people running around investigating the abuse that derives from problems of managing our programs than we have people managing these programs, then something is wrong with our priorities.

APHA recognizes that H.R. 3 is an outgrowth of last year's hearings on the proposed Medicare-Medicaid Anti-Fraud Act and represents a positive revision and a more targeted approach to that measure. We again commend those whose considerable efforts resulted in this bill. We wish to present general comments on changes to sections dealing with factoring, disclosure, and penalties and some detailed observations regarding the PSRO section of H.R. 3.

PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS OF CLAIMS FOR SERVICES (FACTORING-SECTION 2)

We recognize that factoring is a problem and we deplore the practice because it leads to potential abuse. We realize, however, that factoring exists simply because bills are not paid promptly. From the standpoint of the third party payor, factoring is a management problem which is in large part invisible to them. We sincerely doubt that the provisions of Section 2 will be any more effective than the present regulations under Medicaid and Medicare. What is really needed are better claims payment systems in the states and improved career performance in Medicare. It is encouraging to note that many states are moving in the direction of developing Medicaid Management Information Systems (MMIS) which should solve this problem. APHA feels states should be encouraged to continue in this development.

DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION (SECTION 1124)

In an effort to combat the problem of kickbacks and rebate arrangements, the provisions of Sec. 1124 call for the disclosure of information about the ownership and financial arrangements of suppliers and providers.

APHA supports these provisions with two suggested amendments:

It would seem appropriate to amend Sec. 1124(B) to include appropriate State agencies among those that may requese the disclosure information:

Sec. 1124(B) ; page 6, linne 8 "shall promptly comply with any request, specifically addressed to that entity by the Secretary or the Comptroller General of the United States, or the State Agency Under Title XIX or Title V of this Act."

Secondly, we suggest a new paragraph be added to deal with the situation where members of medical staffs have ownership interests in facilities where they admit patients and determine length of patient stay.

"Any entity which is a provider and furnishes care or services with respect to which payment is claimed under Title XVIII, Title XIX or Title V State Plan, pursuant to professional orders from a health care practitioner who has an ownership interest in the entity or who receives payment from the entity on a basis related to the amounts charged or collected for the care or services shall, by regulation, be required as a condition of participation to submit full and complete information with respect to such ownership interest and/or payment."

SHARED HEALTH FACILITY (SECTION 1125)

The purpose of Section 1125 is to define shared health facilities which in common parlance are referred to as "Medicaid Mills". We recognize that this is a very difficult concept to define when the intent is to include the "bad guys" and exclude the "good guys", (e.g. legitimate group practice arrangements.) We believe the committees have developed as good a definition as it is possible to achieve at this time. We know from experience, however, that any definition will need testing to find how and in which ways it may be subverted.

We would like to suggest the possibility of inserting an automatic cancellation clause which would set a time limit on this section. For example, after four years the Secretary would be required to evaluate the effectiveness of the definition before it would automatically continue.

PENALTIES FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS (SECTION 4)

APHA supports the provisions of Sec. 4 which would modify existing penalty provisions for certain acts from misdemeanors to felonies and would increase penalties to $25,000 or five years imprisonment or both. We believe that these penalties will act as deterrents. It might also be advisable to include wording in this section which would require reporting offenses to the state licensing authority under which offenders are currently licensed.

MEDICAID AS PAYOR OF LAST RESORT (SECTION 11)

The wording of Section 11 is specific in its intent to make Medicaid a payor of last resort, notwithstanding any state statutes to the contrary. While we understand the intent of his section, we are concerned with its potential unintended effects. We wish to illustrate two examples of possible unintended effects.

1. A state statute may make counties responsible for care of the indigent, but only if the county has sufficient resources to provide such care. The wording of this section might preclude the provision of care under Title XIX in such states and leave these persons without necessary medical care.

2. A Medicaid program which is attempting to implement, in part, its Early Periodic Screening Diagnosis and Treatment (EPSDT) Program for children using school health programs, may be precluded by this section from engaging in such cooperative efforts.

We recommend that the committees review such possible unintended effects and with general or specific rewording of the action, attempt to avoid these problems.

AMENDMENTS RELATED TO PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (SECTION 5)

Section 5 would significantly broaden the role and responsibilities of PSRO's—a move which raises a number of concerns. PSRO's are organizations which are just getting started and beginning peer review of the medical necessity for services under Medicaid and Medicare. Recent information reported in Medical Care[1] and in the Institute of Medicine study,[2] accessing quality in health care, undertaken at the request of Congress, has documented that there is a lack of evidence that PSRO's have been or are likely to be sufficiently productive to cover their costs. The studies suggest that savings in expenditures and utilization as a result of PSRO type of reviews do not balance with the cost of PSRO operation in either the inpatient or the outpatient area. In light of the evidence to date, we believe that it is inappropriate, at this time, to add new responsibilities and decison makng power to PSRO's or to take away the Secretary's significant control over the scope of PSRO activity.

APHA has four major concerns with this Section as it is presently drafted. Our concerns relate to decision making power, review of shared health facilities, data coordination, and information transfer.

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[1] Robert H. Brook and Kathleen N. Williams, "Evaluation of the New Mexico Peer Review System 1971 to 1973, "Medical Care 14 (Decemebr 1976 Supplement)

[2] Institute of Medicine, Assessing Quality in Health Care: An Evaluation, (Washington, D.C.: National Academy of Sciences, November, 1976)

A. DECISION MAKING

The amendment adding Section 1158(c) would significantly strengthen the responsibility and authority of PSRO's with a corresponding weakening of the responsibility and authority of administering agencies including state Title XIX agencies. Under the present law, when a PSRO indicates a hospital stay unnecessary, the Medicaid agency is prohibited from paying the bill in whole or in part associated with that stay. However, for the vast majority of stays the PSRO does not make a negative decision. The law currently does not automatically mandate the state Medicaid agency to pay all those bills without conducting any review. It is doubtful if the Federal Government can require that states turn over control of their Medicaid expenditures to private organizations which have no accountability to state government. We understand and appreciate the desire to avoid unnecessary duplication of effort; the issue, however, is one of public accountability. Automatically giving such decision making power to private organizations can not meet the test. Unnecessary duplication can be avoided, however, through cooperative arrangements which do not require relinquishing decision making power.

B. SHARED HEALTH FACILITIES

The amendment to Section 1155(G) extends the scope of PSRO review to services furnished in share health facilities and mandates that the Secretary give priority to extending PSRO review to such facilities in areas which have substantial numbers. Our concern with this amendment is twofold. In general, PSRO's have little or no experience with ambulatory care. Evidence reported in Medical Care suggests that claims review is a more cost effective control measure than peer review. Secondly, we are concerned with the great expense associated with attempting to control abuse in shared health facilities through peer review mechanisms such as PSRO's. For example, if nurse reviewers are assigned to review facilities in the areas where shared health facilities are most likely to be situated—they must undoubtedly be accompanied by security guards. In addition to the excessive expense of this kind of operation, the effectiveness of this over-the-shoulder review in attempting to control abuse is highly questionable. What is needed again is more information systems such as MMIS which can target peer review where it is most appropriate and cost effective. To institute an onsight peer review process in the Medicaid mills of New York City, in the absence of an operating MMIS, would be folly.

C. DATA COORDINATION

Section 1165 is proposed to be amended by adding a new Section (b) calling for coordination of data systems.

We applaud the intent to promote cooperation among various established or potential data systems. We believe, however, that clarification is necessary with respect to the intent of the amendment in order to eliminate the possibility that PSRO's will unilaterally develop their own data systems. Rather, they should utilize as much as possible, MMIS, Cooperative Health Statistic Systems, the data systems of Medicare fiscal intermediaries and other public and private hospital data consortia.

Wording which is more specific about such cooperation will eliminate the possibility of duplication resulting in greater expense, the need for providers to report data to several agencies, and the possibility of lack of comparable data thus collected.

D. INFORMATION TRANSFER

The Amendment to Section 1166 calling for the addition of a new Section (b) requiring improved data and information exchange is one of which we heartily approve. We do have one concern that the first subparagraph could be misinterpreted to suggest that PSRO's could exercise their own "discretion" in sharing information. We recommend changing the word "or" on line 15 to "and" and substituting "initiation" for the term "discretion".

In conclusion, a major concern of APHA has been the need to examine the various kinds of controls and incentives which are presently used in the health care field to achieve objectives of access to service, quality of care, and control of expenditures.

In 1974, APHA adopted a resolution which expressed its concern over the lack of data about the interrelationship among various control incentives such as PSRO's, Health Maintenance Organizations, utilization review, provider standards, and capital expenditure controls.

We still believe that these methods have not been sufficiently proven in their effectiveness either independently or in combination. We are encouraged that the hearings today are bringing together the two committees of Congress which could attempt to achieve some rationality and integration among the various controls which have been promulgated.

While the thrust of our remarks have suggested the need to strengthen the data management systems of existing programs such as Medicaid and Medicare, the longer range concern must be with the mechanism by which the public sector provides controls and incentives for improved performance of the private sector responsible for delivery of health services. At the present time as the Institute of Medicine study indicates, we do not have adequate information or knowledge regarding the effect of any one method of control or of the synergistic effects of a variety of controls and incentives. We need, therefore, to promote and encourage efforts and experiments in the states and through PSRO's and HSA's in order to assess the interrelationships among existing control mechanisms and to design and develop new approaches.

Mr. ROGERS. Thank you very much.

It was a very helpful statement, Dr. Robbins.

Mr. Terenzio?

STATEMENT OF PETER TERENZIO

Mr. TERENZIO. Our association would like to congratulate both committees. We think that you are certainly on the right road. Our paper which we have submitted to you does nothing more than to try to strengthen your bill by making its implementation a little more effective.

As far as disclosure of ownership and financial information is concerned, we agreed wholeheartedly with our parent organization and even go one step further and suggest that a system of annual registration and reregistration be developed at the State level. This would make disclosure so much easier, even though it might be necessary at the beginning to make that registration to classes of people in accordance with the amount of money that they take out of the program.

In our opinion, we do not think that including a manager or a person making management services available should be in the definition. This unnecessarily restricts, we think, the number of facilities to be monitored.

Like the U.S. Attorney from the Southern District of New York, we agree wholeheartedly with the penalties; and like him, we go one step further and think that we must also look at the civil side to see what could be done about restitution and recouping some of the money which has been spent and nothing is said to that effect in the bill.

As far as the PSRO is concerned, we, too, like our parent organization, have some qualms particularly on the basis of the job already done. We have some feeling that the State must play some kind of a major role. In the section relating to the monitoring of medical services, quality control and utilization are not defined and we take the opportunity by appending to our paper, a bill introduced into the New York State Legislature by Assembleman Alan Hevis. We believe his bill which has a very good chance of passage in New York State has covered some of the questions concerning quality control and utilization review which we raise.

We agree with the statement made earlier this morning that one of the real important pieces of data we need, are patient profiles. Most of us are convinced that a small number of patients are greatly overutilizing the system and a large number are perhaps underutilizing the system.

We have to know who these people are. We will not know until we have some kind of a disclosure.

Finally, let me give my colleague Dr. Eidsvold an opportunity to make any comment he would like.

Dr. Eidsvold. I would like to make five quick points. The first one is: This will be the first major health legislation in this new administration. The Federal Government should begin to look at State Government as an administrative agent in the prelude to increased Government extension of insurance, I would opt for more of a medicaid-type of approach as opposed to the medicare type. The Federal Government should exercise oversight. It has failed remarkably in the medicaid legislation.

Past legislation placed all medicaid administration in a single State agency. In New York City we have four agencies at State and city level trying to administer a program. They have not succeeded.

Ten years after we had medicaid services, we do not have a computer system to follow patient utilization. The Federal Government should give guidance to the State to put its house in order.

We, of course, in New York State use almost a quarter of all the medicaid funding nationally, although we only have 8 percent of the population. It is admitted by almost everybody we have not done the job we should.

Rather than having the FBI, the Federal District Attorney, HEW, Social Security, involved with the State District Attorney and special prosecutor and the State social service and health organizations, the Federal Government should play a cooperative role and not a duplicatory role in this investigative process.

The main point is that you rely on State government and that everything is not run out of Washington.

The second point has to do with establishing standards. Chapters 4,708 and 4,710 in the attached New York State bill do talk about practices which should be prohibited in terms of overutilization, in terms of abuse, not only fraud.

They talk about quality of peer requirements. Similar to the National Health Planning Act, your legislation should be rather specific to instruct the executive branch as to what you want. If the legislation is too open-ended, it may not be implemented. By having an annual registration and at least an annual audit of these facilities, we will begin to get a grasp of where abuse is occurring.

Third, I want to reemphasize that shared health facilities should include any alliance of health care practitioners which receive substantial amounts of Government money.

I do not think the fact they have to have a manager or management system service is important.

The fourth item has to do with allocation of funds. It is fine to enact all the laws in the world, but unless the Bureau of the Budget allocates moneys or frees up moneys for investigators and auditors, legislation in and of itself will do nothing to correct abuse.

The fifth was to reemphasize a point by the president of our association that there should be intermediate penalties. We in public health have a tradition of encouraging voluntary compliance to statutes. Along with restitution of funds, temporary suspension of licensures, there are other intermediate steps to try to make practitioners practice in a more ethical manner.

Thank you.

[The prepared statement with attachments follow:]

STATEMENT OF THE PUBLIC HEALTH ASSOCIATION OF NEW YORK CITY, PETER TERENZIO, PRESIDENT

My name is Peter Terenzio, J.D., I am President of the Public Health Association of New York City, an organization of over one thousand health professionals deeply concerned with the health care delivery system as related to the health of the people in New York City. Accompanying me is Beatrice Kresky, M.D., Chairperson of the Public Policy and Legislation Committee and Gary Eidsvold, M.D., Governing Council Delegates to the American Health Association.

The Public Heath Association of New York City congratulates both committees for their efforts towards limitation of fraud and abuse in Medicaid and Medicare and for endeavors to contain the spiraling cost of health services. This testimony agrees in principle with the bill and will critique certain sections which in our opinion should be strengthened to make implementation more effective. We agree with the policy stated in Section 2.

DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

Section 3 states that the Secretary may request disclosure of ownership and financial information from any shared health facility. However, it would be administratively far simpler and expedient if any alliance of two or more physicians, any one of whom was reimbursed $5,000 for any one month or an aggregate of $40,000 during a twelve month period from Titles V, XVIII or XIX, must submit to a process of registration and licensure whereby the names of all physicians are stated who work within the common facility along with the name of the individual manager or management corporation, if present, and the location of the facility.

If such a system of annual reregistration is developed, at a state level, the problem of when and for whom public disclosure is requested wolud be eliminated because a listing of possible and probable shared health facilities would be known to government. An adequate computerized system of Medicaid billing by provider and/or practitioner combined with a listing of registrants would make detection and investigation of potential fraud much simpler.

Therefore on page 6, line of H.R. 3, the "complying with request" should be replaced by an adequate licensure and registration of all medical partnership arrangements funded with sizeable amounts of government monies. Government must know the location of physicians affiliated with an organizational structure from whom health services are being bought and the amount of services provided so that government can insure that health services are available to the people of all income levels without fraud and abuse.

Turning to page 12 of H.R. 3, line 17, the definition of shared health facility, in our opinion, should not necessarily include a manager or a person making management services available. This unnecessarily restricts the number of facilities to be monitored. Simply stated, a shared health facility should mandate only 3 components 1) two or more practitioners, 2) using shared health facilities and 3) receiving sizeable amounts of government funding.

PENALTIES FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

The penalties should not be limited to the practitioners or provider of service but should include both the factor and owner of the premise who may accept reimbursement on a sliding scale porportionate to the income received from the government for providing care to poor people. The factor and owner are equally culpable in promoting abuse of Medicaid and Medicare funds.

Voluntary compliance by means of investigation and education may precede criminal action (felony, up to $25,000 fine, and imprisonment up to 5 years). The concept of restitution of funds and temporary suspension of licensure by the state authority may precede criminal action for first offenders. In point of fact up to $150,000 in restitution of funds was received from one shared health facility in New York City.

THE ROLE OF THE PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The locus of authority for implementation and review of utilization and quality cannot be totally federal or solely delegated at a local level to purely voluntary agencies which are totally federally funded. State government must play a major role in regulation of shared health facilities. If public licensure and regulation is required of shared health facilities, the Professional Standards Review Organization may not be solely delegated review authority.

Failure in regulatory activities can perhaps be traced to a dichotomy at the state level whereby one Department is responsible for eligibility and reimbursement (DOSS) and another Department is responsible for utilization review and qualty of care. Furthermore this same type of dichotomy exists when the state function is delegated to a county or municipality. A method of correction might be a unified state plan, with reimbursement and regulation the responsibility of state government rather than bypassing the State Public Health system and delegating responsibility to federally funded voluntary agencies. Decentralization and administrative locus should be given to official agencies given authority by State Legislative bodies. Consequently review, audit and evaluation should not be solely delegated to the Professional Standard Review Organizations but should be delegated to the State Health Department which will work in conjunction with the PSRO. The PSRO must be organizationally more closely related to state government because duplication of activities in monitoring health services in these times of fiscal crisis is expensive and unnecessary. Specifically turning to page 26 of H.R. 3, line 4, which gives responsibility to the PSRO for "designated the number of health care institutions and practitioners" included within a review process, we would like to submit that this should be a function of the State Health Department.

In this Section relating to monitoring of medical services, nowhere is quality control and utilization defined. Examples of care to be avoided should include pingponging, family ganging, overutilization of laboratory and x-ray services, unavailability of services evenings and weekends, inadequate record keeping, "instant" patient-physician encounters, no physician of record, no continuity of records in referring patients for hospital care, etc. Attached to this document is a New York State bill on shared health facilities introduced by Assemblyman Alan Hevesi, Chairman of the Health Committee, which delineates legislative standards for quality control and utilization. The writing of administrative regulations for this "hopefully to be enacted law" should be closely reviewed by your Committees to see that Congressional intent is followed. The recent legislation on health planning, the "National Health Planning and Resources Development Act of 1974" is an example of legislation which clearly defines purpose and function of government authority.

The federal government should assist States in their efforts to adequately monitor not only the care provided by practitioners but also the amount of care received by Medicaid recipients. In New York City today, after nearly ten years of Medicaid administration, a computer system is still not in place to effectively track care received by patients not only in shared health facilities or individual physicians offices but also not in organized ambulatory care programs. Not only is government at fault for not preventing overutilization of health care by consumers but equally as guilty is government not providing care to those individuals insured by Medicaid, who need care but are not receiving it. A recent Rand Corporation study showed that a few Medicaid recipients greatly overutilize Medicaid service—while the vast majority of Medicaid recipients underutilize these services.

We agree with the policy discussed in Sections 6 and 7.

DISCLOSURE BY PROVIDERS OF OWNERS CONVICTED OF CERTAIN OFFENCES

Similar to our comments on Section 3 concerning disclosure of ownership and financial information on shared health facilities, this Section should also be broadened to include reporting names not only of owners convicted of a criminal offense related to federally insured programs, but also the name of any practictioner either salaried or related to the institution as a voluntary attending. This should be part of the health care institutions role in assisting with prevention of fraud and abuse.

In conclusion, the Public Health Association of New York City commends Congress in their efforts to prod government to more effectively and efficiently provide health services to our citizenry. There has been a notable lack of oversight, consultation and support by federal government with respect to assisting State governments to improve their Medicaid programs. Perhaps this is a question of inherent authority not exercised. However, more detailed legislation instructing the executive branch can hopefully improve their monitoring of funds The executive branch must exercise this authority with an expanded work force and should function as a force to develop State capacity and expertise to carry out health service reimbursement and fiscal-quality of care regulation responsibilities as this nation moves toward a form of national health insurance.

STATE OF NEW YORK

S. 2181 **A. 2822**

1977-1978 Regular Sessions

SENATE-ASSEMBLY

February 2, 1977

IN SENATE—Introduced by Sens. GOLD, BABBUSH, BARTOSIEWICZ, BEATTY, BELLAMY, BERNSTEIN, HALPERIN, LEWIS, McCALL, OHRENSTEIN, OWENS, PERRY, TAURIELLO, WINIKOW—read twice and ordered printed, and when printed to be committed to the Committee on Health

IN ASSEMBLY—Introduced by M. of A. HEVESI, CULHANE, G. W. MILLER—Multi-Sponsored by—M. of A. AMATUCCI, BARBARO, BIANCHI, BREWER, BUTLER, CINCOTTA, COCHRANE, CONNOR, CONNERS, D'AMATO, DELLI BOVI, DWYER, FARRELL, FINNERAN, FLANAGAN, FORTUNE, FRIEDMAN, GOLDSTEIN, GOODHUE, GORSKI, GOTTFRIED, GRANNIS, GREENBERG, GRIFFITH, HARENBERG, HAWLEY, HOCHBRUECKNER, KOPPELL, KREMER, LAFAYETTE, LANDES, LEHNER, LIPSCHUTZ, MARCHISELLI, McGEE, McGRATH, M. H. MILLER, MONTANO, M. J. MURPHY, NADLER, NICOLOSI, NINE, ORAZIO, PASSANNANTE, PESCE, POSNER, PROUD, ROBACH, ROSS, SCHUMER, SILVERMAN, STEIN, STEINGUT, P. M. SULLIVAN, VANN, WEPRIN, WERTZ, WILSON, YEVOLI—read once and referred to the Committee on Health

AN ACT to amend the public health law, the social services law and the education law, in relation to providing for the regulation of shared health facilities, and for the deterrence of professional misconduct in relation thereto

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The public health law is hereby amended by adding thereto a new article, to be article forty-seven, to read as follows:

ARTICLE 47

SHARED HEALTH FACILITIES

Section 4700. Statement of legislative findings and intent.
4702. Definitions.

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

4704. Shared health facilities; operating certificates.
4706. Shared health facilities; required notification.
4708. Shared health facilities; prohibited practices; administrative requirements.
4710. Shared health facilities; quality of care requirements.
4712. Shared health facilities; rules and regulations.
4714. Shared health facilities advisory council.
4716. Construction.
4718. Separability.

§ 4700. Statement of legislative findings and intent. The legislature hereby finds that the provision of health care in shared health care facilities has become an important source of health services in this state and that such facilities are important mechanisms for the delivery of health care services which have largely been created by the funding provisions of the state program of medical assistance for needy persons. The legislature also finds and declares that certain practices exist in the medical assistance program which have resulted in abuses requiring the regulation of shared health facilities. The legislature further declares it to be the public policy of the state to regulate shared health facilities and to set necessary standards for review of practices and care rendered in those facilities.

§ 4702. Definitions. For the purposes of this article, the following terms shall have the following meanings: 1. "Program" shall mean the New York state program of medical assistance for needy persons, as provided in title XI of article five of the social services law.

2. "Shared health facility" or "facility" means any arrangement wherein two or more practitioners licensed under the provisions of articles one hundred thirty-one, one hundred thirty-one-a, one hundred thirty-two, one hundred thirty-three, one hundred thirty-seven. one hundred thirty-nine, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred fifty-six or one hundred fifty-nine of the education law, one or more of whom receives payment under the program and whose total aggregate monthly remuneration from such program is in excess of five thousand dollars for any one month during the preceding twelve months, (a) practice their professions at a common physical location; and (b) share (i) common waiting areas, examining rooms, treatment rooms or other space, or (ii) the services of supporting staff, or (iii) equipment; and (c) a person, whether such person is a practitioner or not, is in charge of, controls, manages or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at said common physical location, other than the direct furnishing of professional services by the practitioners to their patients, or a person makes available to the practitioners the services of supporting staff who are not employees of the practitioners. "Shared health facility" does not mean or include two or more such practitioners practicing their profession as a partnership, professional service corporation or other legal entity provided that members of the supporting staff are employees of such legal entity and if there is an office manager, or person with similar title, he is an employee of the legal entity whose compensation is customary and not excessive for such services and there is no person described in paragraph (c) of this subdivision. "Shared health facility" does not mean or include any entity organized pursuant to the provisions of article twenty-eight of this chapter and/or operating under a certificate issued pursuant to the provisions of article thirteen of the mental hygiene law.

3. "Provider" shall mean any physician, dentist, dental hygienist, podiatrist, optometrist, ophthalmic dispenser, chiropractor, physical therapist, occupational therapist, pharmacist, nurse, speech pathologist or audiologist, participating in the program.

4. "Purveyor" shall mean any person, who, whether or not located in a building *which houses a shared health facility, directly or indirectly, engages in the business of supplying to ultimate users any medical supplies, equipment and/or services for which reimbursement under the program is received, including, but not limited to, clinical laboratory services or supplies; x-ray laboratory services or supplies; inhalation therapy services or equipment; ambulance services; sick room supplies; physical therapy services or equipment; orthopedic or surgical appliances or supplies; drugs, medication or medical supplies; eyeglasses, lenses, or other optical supplies or equipment; hearing aids or devices; and any other goods, services, supplies, equipment or procedures prescribed, ordered, recommended or suggested for medical diagnosis, care or treatment.*

5. "Patient" shall mean anyone enrolled in and eligible to receive benefits under the provisions of the program.

§ 4704. Shared health facilities; operating certificates. 1. No shared health facility shall be operated unless the owner or, if the structure in which the shared health facility is located has been leased pursuant to a written lease, the person who leases space in the shared health facility, shall:

(a) possess a valid operating certificate issued pursuant to this article which certificate may specify the kind or kinds of services the facility is authorized to provide; and

(b) establish and maintain a uniform system of reports and audits meeting the requirements of the commissioner.

2. (a) Application for an operating certificate for a shared health facility shall be made upon forms prescribed by the department. The application shall contain:

(i) the name of the facility;

(ii) the kind or kinds of service to be provided;

(iii) the location and physical description of the facility;

(iv) the name and residence address of every person, partnership or corporation having any financial interest in the ownership (including leasehold ownership) of the facility and the structure in which the facility is located;

(v) the name and residence address of every person, partnership or corporation holding any mortgage, lien, leasehold or any other security interest in the shared health facility or in any equipment located in and used in connection with a shared health facility, and a brief description of such lien or security interest;

(vi) the name, residence address and professional license number of every practitioner participating in the shared health facility;

(vii) the name and residence address of the individual designated to assume responsibility for the central coordination and management of the activities of the shared health facility; and

(viii) such other information as the department may require.

(b) An operating certificate shall not be issued by the department unless it is satisfied as to the public need for the existence of such facility at the time and place and under the circumstances proposed for the establishment of such facility and unless it finds that the premises, equipment, personnel, rules and by-laws, and standards of care and service are fit and adequate and that the facility will be operated in the manner required by this article and rules and regulations promulgated thereunder.

3. Each operator shall apply for renewal of the operating certificate on the first day of June next succeeding its initial issuance, and annually thereafter on the first day of June. The annual fee for issuance of an operating certificate shall be seven hundred and fifty dollars, provided, however, that if the initial issuance occurs after the first day of December, the fee shall be one-half of the annual fee.

§ 4706. Shared health facilities; required notification. 1. Each operator shall notify the department within fifteen days of any change in:

(a) the persons, partnerships or corporations having any financial interest in the ownership (including leasehold ownership) of the shared health facility, or

(b) the persons, partnerships or corporations holding any mortgage, lien, leasehold or any other security interests in the shared health facility or in any equipment located in and used in connection with a shared health facility. A statement of the monetary and repayment provisions of that lien or security interest shall accompany such notification.

2. Each operator shall notify the department within fifteen days of the termination of the services of the individual designated to assume responsibility for coordination and management of the activities of the shared health facility, and of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility.

3. Each operator shall notify the department within fifteen days of any termination of the services of any practitioner in the shared health facility, and of the name, residence address and license number of each practitioner newly participating in the facility.

§ 4708. Shared health facilities; prohibited practices; administrative requirements. With regard to shared health facilities: 1. The rental fee for letting of space to providers in a shared health facility shall not be calculated wholly or partially, directing or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health facility is located. The operator of each facility shall file a copy of each lease and any renewal thereof with the department;

2. No purveyor, whether or not located in a building which houses a shared health facility, shall directly or indirectly offer, pay or give to any provider, and no provider shall directly or indirectly solicit, request, receive or accept from any purveyor any sum of money, credit or other valuable consideration for:

(a) recommending or procuring goods, services or equipment of such purveyor, or

(b) directing patronage or clientele to such purveyor, or

(c) influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor;

3. No provider or purveyor may demand or collect any compensation in excess of the fee specified in the fee schedule of the program;

4. No purveyor shall provide to a patient enrolled in the program any services, equipment, pharmaceutical or other medical supplies differing in quantity or in any other respect from that described in the payment invoice submitted by such purveyor to the department. No purveyor shall provide to any patient enrolled in the program any services, equipment, pharmaceutical or medical supplies differing in quality, quantity or in any other respect from that prescribed by the provider;

5. (a) No provider in a shared health facility or person employed in such facility shall refer a patient to another provider located in such facility unless there is a medical need for such referral and unless the records of the referring provider pertaining to such patient clearly sets forth the justification for such referral;

(b) Every provider practicing in a shared health facility who treats a patient referred to him by another provider practicing in the same facility shall communicate in writing to the referring provider the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the patient's permanent record;

(c) The invoice submitted to the program by the provider to whom such patient has been referred shall (i) contain the actual signature and provider number of the referring provider and (ii) identify the medical problem which necessitated the referral;

6. Any pharmacy maintaining a business in or adjacent to the building in which a shared health facility is located shall prominently post a notice informing patients that all pharmaceuticals prescribed in the program may be obtained at any pharmacy of the patient's choice enrolled in the program;

7. No purveyor who maintains a business in the building in which a shared health facility is located shall maintain a door or window opening into the offices or waiting room of the facility, except where the profession of the provider permits the provider to function simultaneously as a purveyor;

8. All provider invoices submitted for services rendered at a shared health facility shall: (a) contain the registration code of the facility at which the service was performed, (b) clearly identify the practitioner who provided the service, and (c) be signed by the provider only after the service has been performed;

9. All orders issued by providers for ancillary clinical services, including but not limited to, x-rays, electrocardiograms, clinical laboratory services, electroencephalograms, as well as orders for medical supplies and equipment, shall contain the code number assigned to the facility at which the order was written; and

10. Each provider or purveyor shall submit a true bill or invoice for services rendered in the program.

§ 4710. Shared health facilities; quality of care requirements. 1. To ensure quality, continuity and proper coordination of medical care, each shared health facility shall:

(a) designate an individual who on a full-time basis shall coordinate and manage the facility's activities. The person so designated shall be responsible for compliance with the provisions of this article;

(b) devise an appropriate means of insuring that (i) patients will be scheduled to return for appropriate follow-up care and (ii) will be treated by a practitioner familiar with the patient's medical history;

(c) post conspicuously the names and scheduled office hours of all practitioners practicing in the facility;

(d) maintain proper records which shall contain at least the following information:

(i) the full name, address and program number of each patient;

(ii) the dates of all visits to all providers in the shared health facility;

(iii) the chief complaint for each visit to each provider in the shared health facility;

(iv) pertinent history and all physical examinations rendered by each provider in the shared health facility;

(v) diagnostic impressions for each visit to any provider in the shared health facility;

(vi) all medications prescribed by any provider in the shared health facility;

(vii) the precise dosage and prescription regimens for each medication prescribed by a provider in the shared health facility;

(viii) all x-ray, laboratory work and electrocardiograms ordered at each visit by any provider in the shared health facility, and their results;

(ix) all referrals by providers in the shared health facility to other medical practitioners and the reason for such referrals; and

(x) a statement as to whether or not the patient is expected to return for further treatment and the dates of all return appointments;

(e) assign an individual and clearly identified practitioner to all patients scheduled for two or more return visits who will function as the source of primary care for that patient and as a central coordinator for all specialty referrals. This assignment may be changed at any time at the patient's discretion;

(f) make available to registered patients either:

(i) the central answering service telephone number of each patient's designated practitioner or such practitioner's personally designated colleagues, or

(ii) a centralized twenty-four-hour-a-day, seven-day-weekly telephone line for off-hour emergency patient questions;

(g) maintain a central day-book registry which shall record:

(i) the name and program number of all patients entering the facility; and

(ii) the chief complaint and the names of all providers whose services were requested by the patient and/or to whom such patient was referred; and

(h) insure that the physical facilities of each shared health facility shall provide for maximum privacy for all patients during examination, interview and treatment.

(i) post comspicuously the telephone number of the agency within the department of health which is responsible for providing information concerning shared health facilities and/or for receiving complaints concerning the provision of health care services at shared health facilities.

2. It shall be the responsibility of each facility's administrator to ensure that patient records and summaries of all patient visits including diagnosis and pharmaceuticals prescribed are at all times available at either the facility or at a place immediately accessible to all health providers at the facility.

3. Nothing in this article shall in any way be interpreted as infringing upon the patient's right to free selection of a personal practitioner.

4. The department shall have the right to inspect the business records, patient records, leases and other contracts executed by any provider in a shared health facility. Such inspections may be by site visits to the facility.

§ 4712. Shared health facilities; rules and regulations. 1. The department shall have the authority to promulgate rules and regulations relative to the quality of care provided by shared health facilities, and to otherwise effectuate the provisions of this article.

2. (a) Subject to the provisions of paragraphs (b) and (c) of this subdivision and after such hearing the department may suspend or revoke the operating certificate of a shared health facility for failure to comply with any provision of this article applicable to such facility, or for failure to comply with the rules or regulations of the department pertaining thereto, or for fraudulent practices on the part of any of the providers of purveyors therein.

(b) No operating certificate shall be revoked, suspended, limited or annulled without a hearing. However, a certificate may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice to the shared health facility following a finding by the department that the public health or safety is in imminent danger.

(c) The commissioner shall fix a time and a place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing shall be served in person or mailed by certified mail to such facility at least twenty-one days before the date fixed for the hearing. The shared health facility shall file with the department not less than eight days prior to the hearing, a written answer to the charges.

(d) All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by certified mail of a copy of the order or determination upon the applicant.

3. The department shall have authority to and may pay directly the owner or owners of any shared health facility for the reasonably related costs incurred by the owner or owners in the operation and maintenance of such shared health facility. Such payments shall be at rates approved by the state director of the budget. Prior to the approval of such rates, the commissioner shall determine and certify to the state director of the budget that the proposed rate schedules for payments to an owner or owners of a shared health facility are reasonably related to the costs incurred by such owner or owners in providing and maintaining efficient health services at such facility.

4. Any provider or purveyor who violates any provision of this article, or of the rules and regulations promulgated pursuant thereto, shall, subject to the findings of a *hearing or review which he may request of the department. be barred from collecting any payments under the program from the date such violation occurs.*

§ 4714. Shared health facilities advisory council.

1. There is hereby created a shared health facilities advisory council consisting of nineteen members appointed by the commissioner for terms of three years. Four of the members shall represent the public interest and shall not be a provider, consumer, or purveyor. Eight of the members shall represent consumers receiving services at shared health facilities, and seven shall be selected from among recommendations made by organizations representing providers and purveyors. Vacancies shall be filled by appointment for the unexpired terms. The shared health facilities advisory council shall select a chairman from among its members.

2. The shared health facilities advisory council shall meet as frequently as its business may require, but in any event at least three times annually. Meetings may be held at the call of the chairman or the commissioner. The commissioner shall designate an officer or employee of the department to act as secretary of the council. Each member shall be reimbursed for expenses actually and necessarily incurred by him in the performance of his official duties.

3. The shared health facilities advisory council shall have no executive, administrative or appointive duties. It shall have the duty to advise the department on all aspects of shared health facilities regulation and operation, including the rendering of recommendations concerning proposed department rules and regulations. The shared health facilities advisory council shall perform such other functions as the commissioner may prescribe.

§ 4716. Construction. 1. Nothing herein shall be construed to impair or affect the powers of the department to engage in any of its necessary or proper activities.

2. Notwithstanding any other provision of law, the provisions of article twenty-eight of this chapter shall not be construed to affect or apply to a shared health facility, nor shall the term "hospital service" as used in that article be construed to mean or include services rendered by individual practitioners participating in a shared health facility.

§ 4718. Separability. If any clause, sentence, paragraph, subdivision, section or part of this article shall be adjudged by any court of a competent jurisdiction to be invalid, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which the judgment shall have been rendered.

§ 2. Paragraphs (e), (f), and (g) of subdivision one of section three hundred sixty-four of the social services law, as added by chapter two hundred fifty-six of the laws of nineteen hundred sixty-six, are hereby amended to read, respectively, as follows:

(e) establishing by regulation reasonable standards, which shall be comparable for all groups, for determining eligibility, consistent with the provisions of this title and the rules of the board; *and*

(f) [promulgating and maintaining the qualifications for physicians employed by public welfare districts as medical directors certified to it by the public health council; and

(g)] publishing and distributing to the public, from time to time, information relating to the medical assistance program, to promote maximum public awareness of the availability of, and the procedure for obtaining, such assistance.

§ 3. Paragraph (b) of subdivision two of section three hundred sixty-four of such law, as amended by chapter six hundred sixty-seven of the laws of nineteen hundred seventy-five, is hereby amended to read as follows:

(b) establishing[,] *and* maintaining [and certifying to the department of social services] standards for all non-institutional [medical] *health* care and services rendered pursuant to this title, *including but not limited to procedural standards relating to the revocation, suspension, limitation or annulment of qualification for participation as a provider of care and services, on a determination that the provider is an incompetent provider of specific services or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety pursuant to section two hundred six of the public health law*, provided, however, that with respect to the standards for non-institutional care and services for the treatment and rehabilitation of eligible individuals certified to the care of the state office of drug abuse services, the department of health shall only establish, maintain and certify such standards as are certified to it by such commission;

§ 4. Subdivision four of section three hundred sixty-four of such law, as added by chapter two hundred fifty-six of the laws of nineteen hundred sixty-six, is hereby amended to read as follows:

4. The public health council shall be responsible for establishing[,] *and* maintaining [and certifying to the department of social welfare] qualifications for [physicians] *persons* employed by [public welfare] *social services* districts as [medical] *professional* directors.

§ 5. Section three hundred sixty-five-b of such law, as amended by chapter one hundred ten of the laws of nineteen hundred seventy-one, is hereby amended to read as follows:

§ 365-b. Local medical plans: [medical] *professional* directors. 1. A local social services medical plan shall be developed and maintained by each social services district under the guidance or direction of [the medical] *a professional* director. Such plan shall conform to the regulations of the department and shall be submitted to the department and the state department of health for review, certification and approval pursuant to the regulations of the department and this title.

2. [(a) The commissioner of social services of each social services district] *The state department of health or the board of health of a county or part-county health district or city health department pursuant to contract with the state department of health* shall appoint a [physician] *person*, possessing the qualifications established by the public health council [and promulgated by the department pursuant to section three hundred sixty-four,] to serve [as a medical director] on a full or part-time basis. [The medical] *Each professional* director shall serve under the general direction of the commissioner of social services and shall have the responsibility for supervising the program of medical assistance for needy persons in [such] *his social services* district, pursuant to the regulations of the department. The *state* commissioner *of health* may authorize two or more social services districts to appoint the same [physician] *person* to serve as [medical] *professional* director in each of such districts.

[(b) Any physician who, on the effective date of this act, is employed by a social services district as a supervisor of medical services or a medical consultant, on a part or a full-time basis, pursuant to the regulations of the department, may be continued in employment, as medical director, notwithstanding paragraph (a).]

3. In addition to any other duty or responsibility which may be assigned or delegated pursuant to law or regulation, each professional director shall be responsible for monitoring the professional activities of providers practicing in his social services district, and shall take all steps required or authorized by law or regulation to ensure that such activities are in compliance with the provisions of this chapter, the public health law and regulations promulgated thereunder, and do not violate the provisions of section sixty-five hundred nine of the education law or regulations promulgated pursuant thereto.

4. For purposes of this section "provider" shall mean any person receiving payment under this title.

§ 6. The education law is hereby amended by adding thereto a new section, to be section sixty-five hundred nine-a, to read as follows:

§ 6509-a. Additional definition of professional misconduct; limited application. Notwithstanding any inconsistent provision of this article or of any other provision of law to the contrary, the license or registration of a person subject to the provisions of articles one hundred thirty-one, one hundred thirty-one-a, one hundred thirty-two, one hundred thirty-three, one hundred thirty-seven, one hundred thirty-nine, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred fifty-six and one hundred fifty-nine of this chapter may be revoked, suspended or annulled or such person may be subject to any other penalty provided in section sixty-five hundred eleven of this article in accordance with the provisions and procedure of this article for the following:

That any person subject to the above enumerated articles, has directly or indirectly requested, received or participated in the division, transference, assignment, rebate, splitting or refunding of a fee for, or has directly requested, received or profited by means of a credit or other valuable consideration as a commission, discount or gratuity in connection with the furnishing of professional care, or service, including x-ray examination and treatment, or for or in connection with the sale, rental, supplying or furnishing of clinical laboratory services or supplies, x-ray laboratory services or supplies, inhalation therapy service or equipment, ambulance service, hospital or medical supplies, physiotherapy or other therapeutic service or equipment, artificial limbs, teeth or eyes, orthopedic or surgical appliances or supplies, optical appliances, supplies or equipment, devices for aid of hearing, drugs, medication or medical supplies or any other goods, services or supplies prescribed for medical diagnosis, care or treatment under this chapter, except payment, not to exceed thirty-three and one-third per centum of any fee received for x-ray examination, diagnosis or treatment, to any hospital furnishing facilities for such examination, diagnosis or treatment. Nothing contained in this chapter shall prohibit such persons from practicing as partners, in groups or as a professional corporation nor from pooling fees and moneys received, either by the partnerships, professional corporations or groups by the individual members thereof, for professional services furnished by any individual professional member, or employee of such partnership, corporation or group, nor shall the professionals constituting the partnerships, corporations or groups be prohibited from sharing, dividing or apportioning the fees and moneys received by them or by the partnership, corporation or group in accordance with a partnership or other agreement; provided that no such practice as partners, corporations or in groups or pooling of fees or moneys received or sharing, division or apportionment of fees shall be permitted with respect to care and treatment under the workmen's compensation law except as expressly authorized by the workmen's compensation law. Nothing contained in this chapter shall prohibit a medical or dental expense indemnity corporation pursuant to its contract with the subscriber from prorationing a medical or dental expense indemnity allowance among two or more professionals in proportion to the services rendered by each such professional at the request of the subscriber, provided that prior to payment thereof such professionals shall submit both to the medical or dental expense indemnity corporation and to the subscriber statements itemizing the services rendered by each such professional and the charges therefor.

§ 7. Subdivision three of section sixty-five hundred twenty-seven of such law, as separately amended by chapters four hundred eighteen and seven hundred twenty-six of the laws of nineteen hundred seventy-six, is hereby amended to read as follows:

3. No [chiropractor] individual who serves as a member of (a) a committee

established to administer a utilization review plan of a hospital, *including a hospital* as defined in article twenty-eight of the public health law or (b) a committee having the responsibility of evaluation and improvement of the quality of care rendered in a hospital as defined in article twenty-eight of the public health law, or (c) any medical or chiropractic review committee or subcommittee thereof of a local, county or state medical, chiropractic, dental, podiatry or optometrical society, any such society itself, a professional standards review organization or an individual when such committee, subcommittee, society, organization or individual is performing any medical or chiropractic review function either described in clauses (a) and (b) of this subdivision, required by law, or involving any controversy or dispute between (i) a physician, chiropractor, dentist, podiatrist or optometrist or hospital administrator and a patient concerning the diagnosis, treatment or care of such patient or the fees or charges therefor or (ii) a physician, chiropractor, dentist, podiatrist or optometrist or hospital administrator and a provider of medical, dental, chiropractic, podiatric or optometrical [benefits] *services* concerning any medical or health charges or fees of such physician, chiropractor, dentist, podiatrist or optometrist, shall be liable in damages to any person for any action taken or recommendations made, by him within the scope of his function in such capacity provided that (a) such individual has taken action or made recommendations within the scope of his function and without malice, and (b) in the reasonable belief after reasonable investigation that the act or recommendation was warranted, based upon the facts [disclosed] *available.*

Neither the proceedings nor the records relating to performance of a medical review function described herein shall be subject to disclosure under article thirty-one of the civil practice law and rules except as hereinafter provided or as provided by any other provision of law. No person in attendance at a meeting when a medical review function described herein was performed shall be required to testify as to what transpired thereat. The prohibition relating to discovery of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting.

§ 8. This act shall take effect on the first day of September next succeeding the date on which it shall have become a law.

Mr. Rogers. Thank you for some very helpful statements, concisely made.

Let me just ask you about this business on the State. Right now, we have a cooperative program with the State medicaid. Many tell us that we are having more difficulty in that than with medicare.

Also, why does the State need an incentive to go ahead and prosecute for fraud and abuse in medicaid when it is to their advantage and it's protecting their money?

Dr. Eidsvold. The State health director from Colorado should answer that. From the New York City experience, I am not that involved. State Government needs help in terms of setting up systems of information and in terms of management orientation. The Federal Government in exercising its oversight responsibilities has a duty if the States are not doing what they should, to get in their with strong advice and leverage.

Dr. Robbins. I think the development of the Medicaid Management Information System is a step in the right direction; and I hope we do not need any special incentive to prosecute in this area.

Mr. Rogers. Evidently, some is neded because we are not——

Dr. Eidsvold. Look at our performance to date. We have not had an effective system. Something has failed somewhere.

Mr. Rogers. Yes. You are very kind to be here. Let me ask you this: Would you approve uniform accounting?

Dr. Robbins. Absolutely. I think we certainly would. I think the obstacle occasionally has been a single form; but as long as there is a uniform chart of accounts and a uniform—a minimum data set to be collected, I think that would certainly be in the right direction.

Mr. Rogers. Mr. Rostenkowski?

Mr. Rostenkowski. No questions.

Mr. Rogers. Mr. Duncan?

Mr. Duncan. I have no questions.

Mr. Rogers. Mr. Corman?

Mr. Corman. No questions.

Mr. Rogers. Mr. Pike?

Mr. Pike. No questions.

Mr. Rogers. Thank you very much for your presence here today.

We had agreed that at 4 o'clock we would hear the Attorney General. We welcome you, Mr. Attorney General.

STATEMENT OF HON. GRIFFIN B. BELL, ATTORNEY GENERAL, DEPARTMENT OF JUSTICE

Attorney General Bell. Thank you.

Mr. Rogers. We appreciate your being able to adjust your schedule on such short notice to accommodate the two committees meeting, the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce on medicaid and medicare fraud and abuse. You are very kind to be present. We are delighted to have you with us. We congratulate you for taking over and we look forward to working with you; and we will be pleased to receive your statement. It will be made a part of the record in full at this point.

You may proceed as you desire.

Mr. Rostenkowski. I would like to join my colleague, Mr. Rogers, in welcoming you to this committee. It is certainly a privilege to have you with us.

Attorney General Bell. Do you want me to give the statement or file it?

Mr. Rogers. If you would like to give it, you may. It will be made a part of the record in full. Do you have copies of it?

You may proceed.

Attorney General Bell. Mr. Chairman, members of the committee, I am very happy to have the opportunity to appear before you this afternoon. The subject of abuse of our health programs is of the utmost concern to the Department of Justice; and as you know, soon after I became Attorney General, I wrote to Secretary Califano to express this concern and to seek his cooperation in a coordinated attack on the problem.

I am pleased to say that HEW shares our concern and our staffs have been meeting to evaluate current efforts and to develop a comprehensive strategy aimed at combating the fraud and abuse in our health care programs.

As you also know, prosecution of violations of Federal statutes involving the medicare and medicaid programs is the responsibility of the Department of Justice. This responsibility is carried out by the 94 U.S. Attorneys and their staffs and the men and women in the criminal and civil divisions of the Department of Justice.

I am sure the members of these two subcommittees are all too familiar with the revelations of fraud and abuse in our health care programs which have come to light in recent years.

I will not recount the sordid examples of the breakdown in the medicare/medicaid programs which have been uncovered.

Just as the public and the Congress have gradually become more concerned about the undermining of the integrity of these programs, so has the Department of Justice become more aware of the need for vigorous investigation and prosecution.

While the medicare program is usually administered by Federal Government, the design of the medicaid program places primary responsibility for enforcement on the States. Many States have responded vigorously; but as a result of the failure of some States to live up to their responsibilities in this area, and the overlapping nature of some of the fraudulent schemes, the Department of Justice has become involved in criminal prosecutions related to both programs.

The Congress has recognized that there are systemic problems in the administration of these programs; and H.R. 3 is a step in the right direction in curing these problems.

Many of our U.S. Attorneys offices have already made significant strides in uncovering and prosecuting these crimes; but the experience of these investigations has taught us that as with many other white collar crimes, these cases are complex and time consuming and require the full-time attention of experienced prosecutors and accountant investigators.

Enforcement, however, is only part of the problem. We hope to work with HEW and with the Congress to tighten up our programs as you are doing in these hearings and to anticipate potential enforcement problems prior to legislative enactment in order to enhance our ability to prevent this type of crime from the outset.

While this program is of high priority, it must be considered in the context of all of the other items placing enforcement demands upon the executive branch.

HEW alone has over 380 programs costing some $130 billion subject to fraud and abuse. Numerous other agencies have similar problems and we are working with all of them. The Department of Justice also has pressing obligations in the other white-collar crime areas of consumer fraud, corporate misconduct, corruption, organized crime, and drug law enforcement.

I commend the work of these two subcommittees on H.R. 3. It is a good bill with some very worthwhile reforms, including the increase in the penalties for fraud on the medicare and medicaid programs from a misdemeanor to a felony.

I would hasten to point out that what is needed to deal with this problem is not major new legislation but a commitment to maintain and protect the integrity of these programs. I am making that commitment to you today on behalf of the Justice Department.

Thank you for this opportunity to appear before you today. I might add that as a Federal judge, I had some experience in seeing some cases prosecuted for medicare fraud, at least two, one of which I wrote the opinion in. They are complicated cases, but they were not beyond prosecution.

Mr. ROGERS. Thank you very much, Mr. Attorney General, for the statement making clear the high priority that your Department will give to this problem of medicaid and medicare fraud and abuse. It is helpful. We had had some testimony to the effect that, in the past, under prior administrations, we had not always gotten high priority. There are some jurisdictions where priority has been given, but many where evidently there has not been. I think it will be most helpful that you have given public testimony, a commitment for giving a high priority to this for your assistants all over the United States.

I think this will be helpful to us in pursuing this program.

Thank you.

Mr. Rostenkowski?

Mr. ROSTENKOWSKI. Thank you, Mr. Chairman.

I am pleased that you are going to be willing and available to cooperate in a vigorous effort with HEW. I think that the fraud and abuse in this program that we need to correct is going to significantly alter our timetable on national health insurance. I think that the public will demand that when a program as large as national health insurance is in place, that there be vigorous enforcement and that we write it so that people will be deterred from stealing dollars designed for the welfare of all the people.

In my discussion with Secretary Califano, he spoke of complete cooperation with you. I just want to encourage that. I think that is essential if we are going to have in place in a very short while—I hope—a national health insurance program that we will be proud of and that we will be able to see legally administered.

Thank you very much.

Attorney General BELL. Thank you.

Mr. ROGERS. Mr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

General, do you think that consolidation of the 380 programs administered by HEW into fewer agencies would be helpful?

Attorney General BELL. Well, I think it would be but I have seen some plans that Secretary Califano has which he will reorganize his Department with, where you will get the same result. I think he is moving rapidly to bring the Department under control.

Mr. CARTER. We have been told that accountants and med-techs are particularly effective in detection of fraud and abuse. Do you think the establishment of a specially trained corps of such investigators would be helpful?

Attorney General BELL. Not only would it be helpful, it would be very necessary. We have bank examiners examine banks. You could not send unskilled people in to examine a bank. I do not think you can find—send unskilled people in to check these programs.

Mr. CARTER. That is so true, as I see it.

I realize that as shocking as they are, that fraud and abuse often get lost in the shuffle of more heinous offenses. Do you think it would be helpful to have a special division within the Department of Justice to handle health fraud, because such vast expenditure of Federal funds are made in this field?

Attorney General BELL. I think it would be. We need some additional resources. We need to also set up special training for some of our U.S. attorneys' people. I am very serious about taking the integrity of these programs and all public programs. I think it would be good for the morality of the Nation to know we are protecting the integrity of our programs, that we are not going to let people commit fraud on the Government. It is just a matter of getting the resources together to do it. I think we know how to do it.

Mr. CARTER. What can be done to insure effective dissemination to various jurisdictions of proven methods of fraud and abuse control found elsewhere?

Attorney General BELL. The fastest message there is when somebody is convicted. That is the way it spreads pretty fast. If we convict people, I think it would not be kept a secret.

Mr. CARTER. Well, it certainly should not be. I hope we can establish an effective program. It is vitally necessary as we have learned over the past years.

Thank you, General.

Attorney General BELL. Thank you, sir.

Mr. ROGERS. Mr. Duncan?

Mr. DUNCAN. I would like to welcome you, Mr. Attorney General, to the committee. I have two or three questions.

Section 6 of the legislation gives the Comptroller General subpena power. What are your thoughts on giving the Comptroller General such power?

Attorney General BELL. In talking with my people on the way over, I am not certain I am in favor of that.

Mr. DUNCAN. Also on page 3——

Attorney General **Bell.** We have presently—we have subpena power now.

Mr. **Duncan.** I interpret your last paragraph on page 3 of your statement that—where you indicate that what is needed is not major new legislation, but a commitment to obtain and protect the integrity of these programs. Do you think we have sufficient laws now to prosecute fraud?

Attorney General **Bell.** Well, I am like the Vermont farmer who was asked if he believe in infant baptism. He said: "I not only believe in it, I have seen it with my own eyes."

I have seen prosecutions. We have a false statement statute on the books which has been widely used, a general false statement statute. I see you adding one into the law which certainly will not hurt anything. It might be helpful. As I say, we need a commitment to vigorous prosecution.

Mr. **Duncan.** I also appreciate the fact you have given that commitment.

Attorney General **Bell.** We have to have more policies. The Attorney General has to set policies, sned the message out to the 94 U.S. attorneys' offices that we are serious about these things. I intend to do that.

Mr. **Duncan.** This problem seems to be more prevalent in the major cities than it is in the smaller cities, say under 500,000. We had—I think one of the U.S. attorneys here the other day who indicated that we do not have people properly trained in the district attorney's office to ferret out the fraud and abuse in these programs.

He seemed to favor a training program.

Attorney General **Bell.** I favor that. We have put in a number of training programs at the Department of Justice. I have been talking to the Director of the FBI about training people in accounting techniques. It is hard to employ accountants, particularly people who understand the sophisticated technology we are faced with. We are going to have to do a lot of training in a lot of areas. This will be one area.

Mr. **Duncan.** Would you advocate that in all the U.S. district attorneys' offices or just in a selected number?

Attorney General **Bell.** Probably do it here and train a few specialists that we can send out in some of the large offices like the southern district of New York, Chicago, Los Angeles, San Francisco. They will have their own training.

Mr. **Duncan.** Thank you for honoring us with your presence here.

Mr. **Rogers.** Mr. Corman?

Mr. **Corman.** No questions.

Mr. **Rogers.** Mr. Ottinger?

Mr. **Ottinger.** Good to have you with us, Attorney General Bell.

I am delighted to hear that you are going to really go after some of these so-called white-collar crimes because I think the taxpayer really is being taken. Every time we put through a program that is intended to help really deserving people. a lot of undeserving people seem to get their hands on the money. These hearings and this committee print indicate just a variety of abuses that have been made in this program. I would hate to see the program impaired because it does help a lot of people who could not otherwise afford adequate care. So much of the money is diverted, I think that is a matter of real concern. I am heartened to hear you are going to go after this in a very serious manner. Anything we could do to help, we would be delighted.

Attorney General Bell. Thank you.

Mr. Rogers. Mr. Pike?

Mr. Pike. No questions.

Mr. Rogers. Mr. Ford?

Mr. Ford. Attorney General Bell, last week the U.S. attorney from Chicago, Ill., testified before these committees. At that time, he informed us that he had set up a special unit in his office whose main function was routing out and prosecuting health care providers who abused the medicare and medicaid programs. In your judgment, is this effective use of legal manpower and do you support the establishment of similar units in the U.S. attorneys' offices throughout the country?

Attorney General Bell. I would not do it in every U.S. attorney's office. In the large cities where they have a sizable number of people in the office, they could do that.

I do not think it would be bad. I would have to know something about how many cases they had. The U.S. attorneys' offices have just a steady flow of cases brought to them by the FBI, the Drug Enforcement Agency, the Alcohol and Tobacco Tax Unit, et cetera, bank examiners. It would depend upon the number of cases that were there. If the inspectors can find the cases, we will find the people to try them.

It may be that you ought to have a small number of people that understand how to try these cases. The two cases I have been in taught me that a skillful prosecutor could try these cases as well as any other case. They are not that difficult to try. It is just what they call over at the Department of Justice the paper chase. You have to get the papers together. You will be able to prove the case if you do that.

Mr. Ford. So in a large metropolitan area, you would support the establishment of such units?

Attorney General Bell. You could do that.

Mr. Ford. That is all, Mr. Chairman.

Thank you.

Mr. Pike. Mr. Chairman?

Mr. Rogers. Mr. Pike?

Mr. Pike. Mr. Chairman, I think Mr. Ford has raised an interesting question. To what extent do you have the freedom in the law or in policy to move specialists around from one office to another in order to prosecute certain types of cases? Are you able to do that or do you do it?

Attorney General Bell. We do it. I do not know if I have the authority to do it, but I have observed for a number of years that it is done.

Mr. Pike. That is all I wanted to know. I think it is a wonderful idea. I have a little experience in this regard. I was prosecuted by the U.S. attorney once. It involved migratory game birds. I will only say that the man who prosecuted me knew all the law in the world about robbing banks but he did not know a damned thing about migratory game birds.

Attorney General Bell. I hope you found a sympathetic judge. That is more important.

Mr. Pike. I did not trust the judge, but I had a wonderful jury.

Mr. Rogers. Mr. Martin?

Mr. Martin. Thank you, Mr. Chairman.

Mr. Attorney General, good to see you again. I want to thank you for the commitment expressed in your statement here to deal with these programs, to see that the abuse is halted, to see that the fraud is brought to trial.

You said that you needed additional resources to do this, and you explained there are other problems you have as well. This is certainly one that needs to be given a lot of attention, to help us get an understanding of these additional resources could you elaborate on that point a little bit as to what you estimate your needs are?

Attorney General Bell. I could not give an estimate on this one program, but I am finding in what I call the line definitions at the Department of Justice—where they try the cases—they are short of people. We seem to have more backup people, at least as many as we can use.

We do not have the line lawyers. I think that is true, to some extent, in the U.S. attorney's office. That is not the committee's problem. I am going to make some recommendations and try to get the money to get the people, and also we are going to start our own training program on parallels. We will be able to get help that way. Maybe we can transfer people out of other jobs and ask them to take parallel training and start operating on a more efficient basis.

I am sure as the days go by. I will be asking for more resources. If we are going to get serious about crime and about preventing fraud in the Federal Establishment, we are going to have to have the resources to do it.

Mr. Martin. It seems to me, sir, that the sooner you are in a position to do that, the more helpful it will be to us. Although this particular bill focuses on the legal standards and on the penalties, it seems to me that we could do a lot more to help you, both you and the States, just as earlier witnesses have remarked on the need for your agency, your U.S. attorneys out in the field to have someone in their office who knows the nuances and the mystique. I believe the word was used, of the health care industry and the kinds of abuses that crop up there.

Just as someone is needed who understands that language and those kinds of problems and what to look for, it has been argued the same thing is needed in the individual States, special units that would bring together the accountants, the investigators, the prosecutors in one office where they could focus on this priority. There may be other priorities, but at least in one office, this is the priority. They have expressed to us that otherwise you have a very great difficulty getting an accountant who is assigned to another office to take the time to come over and work on this problem because someone else decides that something else is a priority and therefore, this one does not get attended to.

I do not believe that is the entire problem. I think there are a lot of other difficulties in this area. Part of the solution seems to me has to be not just tougher standards and stricter penalties, but also more certain punishment.

Attorney General BELL. Well, I have been meeting with a lot of groups since I came to Washington. I met just a few days ago with 21 State Attorneys General. I met with a large group of big city prosecutors, State prosecutors. I met with a group of governors. What we are trying to do is get a national policy on what we call the delivery of justice.

That will include prosecutions. I want the FBI and the other Federal investigative forces to make up the cases. We will then decide who is going to try them. Should it be in a State court or in the Federal? The same would follow with medicaid, where we find a medicaid violation, we will be working with the States to prosecute some of them. Some we will prosecute. What we need very badly in this country is a national policy where we—under a system of Federalism there is a cooperation between the State and Federal forces. Once we get that going, I think you will see law enforcement pick up some.

Mr. MARTIN. Would you, on the basis of your study so far, be in a position to tell us your opinion on the idea of requiring and providing the necessary funds to pay for special enforcement units in each State? That could specialize on this area? Where they could learn how to deal with it and come to grips with it.

Attorney General BELL. I am not sure I understand the Inspector General's Office in HEW, but if they are going to work like bank examiners, they are going to pick up medicaid and medicare fraud at the same time.

If you go into a nursing home—I had a good deal of experience with that because my mother was in one for over 3 years. They have medicare and medicaid patients. The same inspectors are trying—finding violations in both programs as I understand it. That is how it would work. I may be wrong about that. I have never seen a place that did not have both medicare and medicaid in the same building.

Mr. MARTIN. I am talking about health care delivery problems generally having specialists in a special unit who would deal with all of these problems of delivery of heath care?

Attorney General BELL. That might be something that is necessary. I am afraid I do not know enough about it to answer that. It may well be. Generally speaking, I am not in favor of stationing a Federal employee on State payrolls. I think the States ought to run their own enforcement and we ought to run ours. We ought to work together.

Mr. MARTIN. That is essentially the proposal, something like you have in the Solicitor General's Office where you have a team of people who can really become have acquainted with the problems that come up in enforcing these laws pertaining to medicaid and medicare.

Attorney General BELL. I think if the Inspector General's Office operates in the way the bank examiners do—I use that as an analogy—they will be checking all the providers, they will be experts. You can pick up many things wrong if you just understood computers, data retrieval. They will develop expertise. If they are not going to do that, then you need to have inspectors. There is no doubt about that. They have to be skilled, experts.

Mr. MARTIN. Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. I have no questions. I just wanted to welcome the Attorney Genearl here, thank him for coming and say that we look forward to working with him and we all appreciate your commitment to protecting the integrity of the Medicaid and Medicare programs.

I think that is certainly something we all are concerned with in the country; and I believe you are going to do it. Thank you very much for being with us.

Attorney General BELL. Thank you.

Mr. ROGERS. General, may I ask just a few questions quickly?

From the discussion with Mr. Martin, would you anticipate that the Department of Justice itself would have any responsibility for ferreting out cases of fraud or abuse in the medicare-medicaid field?

Attorney General BELL. We would not as a form of inspection.

Mr. ROGERS. For instance, the FBI?

Attorney General BELL. If the FBI was given jurisdiction over the inspection, we could very well do it; but they do not—they do now do that.

Mr. ROGERS. In other words you feel that until some fact is reported to you by HEW, you would not basically be involved?

Attorney General BELL. We would not commence our investigation. At the time they tell us there is a suspected fraud, and ask us to look into it, we would.

Mr. ROGERS. Then maybe the manpower needs to go to HEW.

Attorney General BELL. It needs to go to somebody to be the inspector.

Mr. ROGERS. To do the first inspecting job?

Attorney General BELL. Right.

Mr. ROGERS. As I understood it, you would be willing to set up a special group in your Department if you felt that it was necessary and you will send out the words to all of the 94 district attorneys that you want priority given in this area?

Attorney General BELL. Right.

Mr. ROGERS. Which I certainly think will be helpful.

Now, let me just go into this: I am somewhat concerned from the reports we are getting now with the fact that the FBI may be needed in many areas, because there seems to be developing not just what we think of as white-collar crime here where people are padding bills a little bit, but it seems that there is some movement of the criminal element to really take over in medicaid mills, in some of the social programs because there is so much money involved; and perhaps you saw the report in the Post I guess on the California situation where they are now probing what they call a Chicano Mafia moving in in this area in drugs and in the social programs. They have just had the death of a woman they feel was the gangland style death. She was bringing in records and was killed, and the records disappeared.

Then I notice in 1976 there was a case in Chicago where there was a man indicted, I believe, for some fraud of $10 million; and they felt he was a front for a Mafia element there. So it seems to be developing rather rapidly here that not only are we having those who may be involved in the health field in some way having white-collar crime but because of the vast sums, we are having organized crime move into this field, and that is why I think it will be important to have the FBI alerted to this and your attorney, district attorneys as well as having HEW do their inspection.

Attorney General Bell. I think what they ought to do is have examiners to go out and examine the records of the suppliers. If they find some suggestion of wrongdoing, notify the U.S. attorney. We will get the FBI on it.

Mr. Rogers. Fine.

Attorney General Bell. I think that would be the way to go about it.

I think the assurances you have given us here are most helpful. We appreciate your being here to give the assurance to the American public. We look forward in working with you in trying to clean up some of the fraud and abuse.

I think we all have questioned you.

Mr. Rostenkowski [presiding]. Mr. Brewer, Dr. Jahiel, Mr. Crowley?

Welcome to the committee, gentlemen.

STATEMENTS OF DON BREWER, VICE PRESIDENT, WILLIAM A. GEOGHEGAN, LEGAL COUNSEL, AND BRUCE D. THEVENOT, ADMINISTRATOR, GOVERNMENT SERVICES, REPRESENTING AMERICAN HEALTH CARE ASSOCIATION; RENE I. JAHIEL, M.D., REPRESENTING CITIZENS FOR NURSING HOME REFORM; AND DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT, AND LAURENCE F. LANE, DIRECTOR FOR PUBLIC POLICY, REPRESENTING AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Rostenkowski. If you care to summarize your testimony, you are free to do that with the assurance that your testimony will be inserted in the record in its entirety.

If you would like to identify yourselves and proceed into your statement, the committee is now ready to receive it.

Mr. Brewer?

STATEMENT OF DON L. BREWER

Mr. Brewer. Mr. Chairman, I am Don L. Brewer, vice president of the American Health Care Association, and chairman of the association's committee on government relations.

With me today are Bruce D. Thevenot, our director of Government services, and William A. Geoghegan of the firm of Pierson, Ball and Dowd, our general counsel.

We will summarize our testimony at this time.

The American Health Care Association welcomes and greatly appreciates the opportunity to appear before the distinguished House subcommittees on which legislative responsibility for long-term health care issues has been imposed.

We regret and deplore, however, the circumstances which have occurred in the past which require the Congress and ourselves to address the subject of fraud and abuse in the medicare-medicaid programs.

The AHCA is in its 28th year of organization. We are by far the largest group of nursing home providers with a membership of more than 7,500 or approximately 50 percent of all skilled and intermediate care facilities. The total bed capacity of our membership exceeds 600,000.

AHCA serves its membership, and through them the hundreds of thousands of patients cared for in their homes, in a variety of ways.

We attempted to summarize in our testimony those things for you. I hope you will refer to page 17 of our statement on fraud and abuse.

Our purpose in calling these association services and activities to your attention is to illustrate some positive action we have taken in an effort to improve the quality of care rendered to the patients in our home. The presence of high quality care is the best evidence of the absence of patient abuse.

AHCA is well aware that efforts to eliminate fraud and abuse in the medicare and medicaid program must always be vigorously pursued. We are today taking the occasion of these hearings to release to our members and the public an association statement on the subject. A copy of the statement is attached, which we request be included in the hearing record.

Mr. Rostenkowski. Without objection, so ordered.

Mr. Brewer. We add, incidentally, that this statement was in the process of development prior to our notice of these hearings.

Our attached statement reflects our belief that an effective effort directed at fraud and abuse must rely in the long run on systems and procedures which reduce the incentives and the opportunities for subversion of the program by its administrators or constituents.

This implies the presence of both positive and negative influences—positive, in the form of adequate resources, efficient program management, clear and concise rules and regulations—negative, in the form of regular, effective monitoring and swift, sure retribution for offenders consistent with due process.

The next part of the testimony is taken from our statement. We do illustrate some common examples of financial abuse and suggest methods of elimination of many of them.

On page 9, we direct our attention now to the legislation under consideration, H.R. 3. We are in complete support of its objectives, and for the most part it will not impose requirements on our members that are new or not presently observed.

Section 2 (b) and (c) proscribe with certain exceptions the factoring by providers of medicare and medicaid claims. To the best of our knowledge, factoring or assignment of such claims by long-term care providers occurs infrequently. There are circumstances, however, when delay in the payment of medicare and medicaid claims to providers can impose serious cash flow problems. We suggest the bill be amended so that when this happens, providers be permitted to assign such cailms with prior approval of the appropriate Federal or State agency.

In sum, we support the the concepts of H.R. 3 and any reasonable reporting and disclosure requirements imposed on providers, especially if they contribute to the elimination of fraud and abuse in the programs.

No discussion of fraud and abuse in the medicare and medicaid programs can be complete without some reference to the adequacy of provider reimbursement.

Although indequate reimbursement can never justify financial fraud or patient abuse, it can make it impossible to provide the quality of care our elderly citizens are entitled to receive.

Congress recognized that many States were paying nursing homes less than reasonable costs, however defined, in 1972 when it enacted section 249 as part of Public Law 92–603.

That section provides that as of July 1, 1976, all States were to reimburse skilled and intermediate care providers on a reasonable cost-related basis. Although HEW and the States were given 4 years to prepare for the change in reimbursement requirements, it was not until July 1, 1976 that the Secretary of HEW issued implementing regulations. These regulations state that HEW will not require compliance with the Congressional mandate to move to reasonable cost-related reimbursement until January 1, 1978.

This is a direct violation of law which has been characterized as such by the Comptroller General in a letter to Congressman Pepper.

The full text of the Comptroller General's opinion is attached.

This refusal on the part of the prior Secretary of HEW to comply with the statutory requirement that all States reimburse skilled and intermediate care facilities on a reasonable cost-related basis, effective July 1, 1976, has resulted in the filing of several lawsuits against the Secretary in various States to compel compliance, including one now pending in the District of Columbia filed by AHCA.

That the problem is real is illustrated by the situation in Alabama. In one of the lawsuits referred to pending in that State, the head of the State agency, Dr. Holzworth, recently testified in a deposition that since 1972, Alabama has computed a reasonable cost-related payment rate for each nursing home on the basis of audited cost information obtained from each home and reviewed by the State and its outside contractor, Ernst & Ernst. At present, however, those reasonable cost-related rates are not being paid.

Instead, the State has imposed ceilings on payments which are not exceeded, even though the rate found by the State to be reasonably cost-related may be several dollars per day higher. Those ceilings will be lowered $3 per day more effective April 1, 1977.

The elimination of fraud and abuse in the medicare-medicaid programs requires that all involved, both in the public and private sector, abide by the laws and regulations under which the programs operate.

We urge the Congress to use its influence to see to it that the regulations under discussion immediately are modified to the extent they are presently operating to effectively delay the congressional mandate so clearly expressed in section 249, Public Law 92–603.

In coping with the subject of these hearings, we are confident the Congress will understand the complexity of the problem and not limit its focus on the small minority of dishonest persons who have cheated the programs, and even worse, abused the beneficiaries committed to their care.

Much of what has gone wrong is the result of the complexity and uncertainty of the financial reporting requirements imposed on providers and the inadequacy of audit procedures.

When a provider is able to charge a valuable Renoir painting to the medicaid program and go undetected for several years as much is revealed about the near total lack of auditing procedures in some states as the dishonesty of the provider involved.

Unfortunately, when incidents of this kind are revealed and receive widespread publicity, all providers suffer the consequences.

Fortunately, however, there are knowledgeable persons who view the problem in proper perspective, such as Mr. M. Keith Weikel, HEW's medicaid chief, who recently observed, following a special medicaid audit review in Massachusetts, that although many irregularities were found, some serious, the review "confirmed the fact that the majority of medicaid providers are conscientious and honest in their dealings with the program."

We trust the Congress as a whole agrees and you may be assured of the full cooperation of our association and its members in striving toward what most assuredly is a common goal—high quality care for the people we serve, in a safe and wholesome environment, efficiently and honestly rendered and reasonably reimbursed.

[The prepared statement and attachments follow:]

Statement of American Health Care Association

Mr. Chairman Rostenkowski, Mr. Chairman Rogers and members of the Subcommittees before whom we appear.

My name is Don L. Brewer, Vice President of the American Health Care Association, and Chairman of the Association's Committee on Government Relations. With me today are Bruce Thevenot, our director of Government Relations, and William Geoghegan of Pierson, Ball & Dowd, our general counsel.

The American Health Care Association welcomes and greatly appreciates the opportunity to appear before the distinguished House Subcommittees on which legislative responsibility for long term health care issues has been imposed. We regret and deplore, however, the circumstances which have occurred in the past which require the Congress and ourselves to address the subject of fraud and abuse in the Medicare-Medicaid programs.

The AHCA is in its twenty-eighth year of organization. We are by far the largest group of nursing home providers with a membership of more than 7,500, or approximately 50% of all skilled and intermediate care facilities. The total bed capacity of our membership exceeds 600,000. Included within our membership are both proprietary and non-proprietary or voluntary facilities (the latter consisting of approximately 20% of our membership). AHCA is a federation of state associations and membership in an affiliated state association is a requirement of membership in our organization. There is one affiliated association in each of 49 of the 50 states.

We wish to emphasize at the outset that our membership recognizes that the Medicare and Medicaid programs were created and enacted solely for the purpose of providing health care services to eligible beneficiaries, primarily the elderly and indigent, and not for the benefit of the providers who render those services. Nevertheless, it is obvious that literally hundreds of thousands of many kinds of providers—doctors, nurses, hospitals, nursing homes, druggists, and others providing health care services and supplies—are essential to fulfilling the objectives of these programs. Our members are proud of our participatory role in this great national effort.

AHCA serves its membership, and through them the hundreds of thousands of patients cared for in their homes, in a variety of ways. Most important is the educational service we render to our members assisting them to provide the patients they serve with the quality of care, in a safe and wholesome environment, that we as a nation have the right to expect and demand. The substantial majority of those patients are the elderly poor, although our total patient census includes increasing representation of other who require long term nursing care such as the mentally retarded and younger persons suffering chronic effects of serious illness or personal injury.

AHCA focuses many of its educational activities toward in-service training in long term care facilities. In addition to provide a variety of staff development training manuals for ancillary staff (including nurse aides), AHCA also offers a series of audio-visual training films for all long term care personnel. This program, known as the Instructor, is used by almost one thousand long term care facilities. It presently consists of 41 films addressing staff skills that are essential to quality patient care and efficient facility management. AHCA is currently presenting a series of 10 regional seminars on the Administrative Aspects of Infections Control in Long Term Care Facilities, under a DHEW Contract (HRA 230–76–0278). Designed for administrators and directors of nursing, these workshops stress policies and procedures to protect patients from infections. At it annual convention AHCA offers an extensive educational program for administrators and others. Last year, over 800 individuals attended these sessions. Another service provided by AHCA is an educational book service, whereby current books on administration and patient care are made available.

Another important service we perform is to represent the views of our members before numerous Federal and state legislative and administrative agencies concerned with long term care law and issues. The complexity of the statutory and regulatory scheme under which our membership must operate, and the need for them to be informed fully of its requirements, make an organization such as AHCA a necessity.

Our purpose in calling these Association services and activities to your attention is to illustrate some positive action we have taken in an effort to improve the quality of care rendered to the patients in our home. The presence of high quality care is the best evidence of the absence of patient abuse.

AHCA is well aware that efforts to eliminate fraud and abuse in the Medicare and Medicaid program must always be vigorously pursued. We are today taking the occasion of the these hearings to release to our members and the public an Association statement on the subject. A copy of the statement is attached which we request be included in the hearing record. We add, incidentally, that this statement was in the process of development prior to our notice of these hearings.

Our attached statement reflects our belief that an effective effort directed at fraud and abuse must rely in the long run on systems and procedures which reduce the incentives and the opportunities for subversion of the program by its administrators or constituents. This implies the presence of both positive and negative influences—positive, in the form of adequate resources, efficient program management, clear and concise rules and regulations—negative, in the form of regular, effective monitoring and swift, sure retribution for offenders consistent with due process.

Much of the financial abuse in nursing homes can be traced to faulty methods of payment for services coupled with insufficient auditing of financial records of nursing homes. Some of the most common faults which have existed in the payment methods used by some though not all of the state Medicaid programs are as follows:

(1) Inadequate rates to support levels of services required by legal standards;

(2) Lack of uniform procedures for collecting cost data to support the rate-making process;

(3) Imprecise definitions of allowable costs which nursing homes may claim;

(4) Inadequate requirements for maintenance of financial records by nursing homes;

(5) Excessive delays in payment for services rendered;

(6) Failure to perform sufficient desk and field audits to verify the accuracy and appropriateness of claims for payment by nursing homes, particularly where payment is made on a cost or cost-related basis.

Brief comments are in order with respect to the most common examples of financial abuse by nursing homes.

(1) Abuses involving inflation of service costs resulting from self-dealing, kickbacks, or bribes.

There are three principal methods of detecting or discouraging financial abuse which takes the form of inflated claims resulted from the payment by the provider of higher-than-market prices for supplies and services procured under non-arm's-length arrangements.

(a) Comparison of providers' costs to average or "standard" costs for the same items or services in the open market.[1]

(b) Strict rules for disclosure of ownership and disclosure of arrangement with substantial contractors.

(c) Instituting prospective payment rates on a standard cost basis or approved budget basis or class basis rather than payment of each provider's actual costs on a retrospective basis.

Transactions among parties related by common ownership do not necessarily equate to abuse, and indeed can have the desirable result of increased efficiency and cost savings. Proper safeguards are necessary, to be sure. Kickbacks and bribes are presently illegal under the Federal Medicaid law. Sec. 1909, Social Security Act.

(2) Abuse related to depreciation and interest payments on capital assets.

Abuses in the area of mortgage or lease payments can occur where the payment pays individual facilities capital cost allowances on the basis of overstated property values, higher than necessary construction costs, or luxury accommodations.

The best options for minimizing abuse in the property area are:

(a) Disclosure of ownership and financing arrangements;

(b) Use of qualified appraisals to establish fair market value of assets where necessary;

(c) Limitation of depreciation basis to the lesser of (1) fair market value or (2) replacement cost less accumulated depreciation upon transfer of ownership at a gain;

(d) Use of construction indices or establishment of ceilings on construction costs recognized for purposes of payment of capital expenses;

(e) Ceilings on allowable mortgage interests rates;

(f) Substitution of imputed allowances for actual depreciation, interest, and related capital expenses.

The above options are not mutually exclusive. Allowances for use of buildings and equipment must be sufficient to permit providers to meet reasonable amortization schedules and provide for the maintenance and replacement of assets. Additionally, owners are entitled to sell their property at a fair gain or enter into bona fide leases. Undue restrictions will drive much-needed capital from the nursing home industry and result in further bed shortages and unnecessary expenditures for costly hospital care.

We direct our attention now to the legislation under consideration, H.R. 3. We are in complete support of its objectives, and for the most part it will not impose requirements on our members that are new or not presently observed.

Sec. 2(b) and (c) proscribe with certain exceptions the factoring by providers of Medicare and Medicaid claims. To the best of our knowledge factoring or assignment of such claims by long term care providers occurs infrequently. There are circumstances, however, when delay in the payment of Medicare and Medicaid claims to providers can impose serious cash flow problems. We suggest the bill be amended so that when this happens providers be permitted to assign such claims with prior approval of the appropriate Federal or State agency.

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[1] NOTE.—Establishment of "standard" costs can be accomplished by the aggregation of the array of data derived from uniform cost reports, supplemented by marketplace sampling. Some items, such as prescription drugs fluctuate widely in acquisition cost and are therefore not easily standardized.

Sec. 3 of H.R. 3 relates to disclosure of ownership and financial information most of which our members are already providing. We do have some concern about the breadth of the reporting requirements to the extent that information may be required of providers to which they do not have access or which might be difficult to obtain. We refer to the requirements that lease, rental or mortgage interests of five percent or more in a facility be reported. In some situations these interests might not be known to providers on whom the reporting requirements are imposed.

In sum, we support the concepts of H.R. 3 and any reasonable reporting and disclosure requirements imposed on providers, especially if they contribute to the elimination of fraud and abuse in the programs.

No discussion of fraud and abuse in the Medicare and Medicaid programs can be complete without some reference to the adequacy of provider reimbursement. Although inadequate reimbursement can never justify financial fraud or patient abuse it can make it impossible to provide the quality of care our elderly citizens are entitled to receive. Congress recognized that many States were paying less than reasonable costs, however defined, in 1972 when it enacted Sec. 249 as part of P.L. 92–602. That section provides that as of July 1, 1976 all States were to reimburse skilled and intermediate care providers on a reasonable cost related basis. Although HEW and the States were given four years to prepare for the change in reimbursements it was not until July 1, 1976 that the Secretary of HEW issued implementing regulations. These regulations state that HEW will not require compliance with the Congressional mandate to move to reasonable cost related reimbursement until January 1, 1978. This is a direct violation of law which has been characterized as such by the Comptroller General in a letter to Cong. Pepper, dated January 31, 1977, from which we quote:

"We conclude, therefore, that the expressions in the regulations of July 1, 1976, further postponing the date upon which States will be required to meet the provisions of 42 U.S.C. § 139(a)(13)(E) are contrary to the provisions of that statute in so far as they purport to relieve the States from the requirements of providing reasonable cost related reimbursement to skilled nursing and intermediate care facilities. Accordingly, our answer to your questions 1 and 2 are that the Secretary of HEW has no authority to delay the implementation of section 249 of Pub. L. No. 92–603 beyond July 1, 1976, and that those portions of the regulations of July 1, 1976, that purport to postpone the date upon which State plans must conform to 42 U.S.C. § 139a are contrary to the statute."

The full text of the Comptroller General's opinion is attached.

This refusal on the part of the prior Secretary of HEW to comply with the statutory requirement that all States reimburse skilled and intermediate care facilities, on a reasonable cost related basis, effective July 1, 1976, has resulted in the filing of several lawsuits against the Secretary in various States to compel compliance, including one now pending in the District of Columbia filed by AHCA. That the problem is real is illustrated by the situation in Alabama. In one of the lawsuits referred to pending in that State the head of the State agency, Dr. Holzworth, recently testified in a deposition that since 1972 Alabama has computed a reasonable cost related payment rate for each nursing home on the basis of audited cost information obtained from each home and reviewed by the State and its outside contractor, Ernst & Ernst. At present, however, those reasonable cost related rates are not being paid. Instead, the State has imposed ceilings on payments which are not exceeded, even though the rate found by the State to be reasonably cost related may be several dollars per day higher. Those ceilings will be lowered three dollars per day more effective April 1, 1977, under a plan adopted February 17, 1977, by the State of Alabama Committee of Public Health, the single state agency designated in Alabama to carry out its Medicaid program.

Dr. Holzworth admitted that such ceilings were inconsistent with the concept of reasonable cost payment and resulted in the failure of Alabama to pay costs which it has recognized as proper and necessary. He stated further that the HEW regulation delaying the effective date of implementation of reasonable cost related payment was one of the reasons why payments under the ceiling method were still being made, even though those ceiling are inconsistent with the reasonable cost related concept.

The elimination of fraud and abuse in the Medicare-Medicaid programs requires that all involved, both in the public and private sector, abide by the laws and regulations under which the programs operate. We urge the Congress to use its influence to see to it that the regulations under discussion immediately are modified to the extent they are presently operating to effectively delay the Congressional mandate so clearly expressed in Sec. 249, P.L. 92–603.

In coping with the subject of these hearings we are confident the Congress will understand the complexity of the problem and not limit its focus on the small minority of dishonest persons who have cheated the programs and even worse abused the beneficiaries committed to their care. Much of what has gone wrong is the result of the complexity and uncertainty of the financial reporting requirements imposed on providers and the inadequacy of audit procedures. When a provider is able to charge a valuable Renoir painting to the Medicaid program and go undetected for several years as much is revealed about the near total lack of auditing procedures in some states as the dishonesty of the provider involved. Unfortunately when incidents of this kind are revealed and receive widespread publicity all providers suffer the consequences. Fortunately, however, there are knowledgeable persons who view the problem in proper perspective, such as Mr. M. Keith Weikel, HEW's Medicaid chief, who recently observed, following a special Medicaid audit review in Massachusetts, that although many irregularities were found, some serious, the review "confirmed the fact that the majority of Medicaid providers are conscientious and honest in their dealings with the program." We trust the Congress as a whole agrees and you may be assured of the full cooperation of our Association and its members in striving toward what most assuredly is a common goal—high quality care for the people we serve, in a safe and wholesome environment, efficiently and honestly rendered and reasonably reimbursed.

American Health Care Association Policy Statement On Fraud and Abuse

Since its inception a decade ago, the Federal-State medical assistance program (Medicaid) has grown by leaps and bounds. In fiscal year 1978 the Medicaid program will serve almost 25,000,000 Americans and will expend nearly $17 billion. Some $5 billion, or 40% of the total medical vendor payments, will be used to provide long-term institutional care for approximately 500,000 aged and chronically ill persons.

The magnitude of these figures portrays why it is important to assure that every available dollar goes to purchase services that are of high quality and truly needed. If the American people are to continue to willingly shoulder the financial responsibility to provide decent health care for those unable to care for themselves, public trust in the administration and integrity of the Medicaid program must be established and preserved.

Congressional hearings and numerous investigations during the recent past have documented examples of fraud and abuse among both providers and recipients of Medicaid services, particularly in major urban areas. The findings have run the gamut of doctors, hospitals, pharmacists, nursing homes, laboratories, and suppliers under all types of ownership. Recurring revelations of wrongdoing are an affront to the large majority of honest health care practitioners and institutions, robbing them of vitally-needed public support and confidence.

In actual dollar terms, it is probable that excessive utilization and inefficient delivery of service waste more dollars than are siphoned off by abusive practices. Nevertheless, the notion that some Americans are bilking all Americans in the important and sensitive realm of health care for the poor and aged has an enlarged and destructive impact on the stability of the partnership between government and the private system of health care delivery.

Permitted to continue unchecked, the present unacceptable operation of the Medicaid program will surely lead to either a reduction in government support of health care or an increase in direct Federal control of the health care system. Either way, we will all be the losers as the quality and availability of services will be reduced.

The American Health Care Association the nation's largest nursing home organization is determined to see that this issue is met fairly, effectively, and head-on! The root causes of fraud and abuse must be identified and eliminated. Health care professions have a shared responsibility with government and the public at large to put lasting solutions into effect—solutions that will preserve the fundamental privileges and protections of our free society.

FRAUD AND ABUSE IN PERSPECTIVE

Because the phrase "fraud and abuse" has become an increasingly imprecise euphemism for an entire catalog of problems and suspected problems, it is necessary to define our terms before examining the specific problems associated with actual or alleged wrongdoing in the nursing home area. A dictionary definition of fraud is:

"Deceit, Trickery; specifically: intentional perversion of trust in order to induce another to part with something of value or surrender a legal right".[2]

Abuse is a broader term. While it can have essentially the same meaning as *fraud*, it can also mean simply a "wrong or improper use or action".[2] Defined in this way, it is evident that fraud denotes the presence of two conditions which abuse does not require: (1) a knowledge of the truth, and (2) an intentional perversion. By contrast, abuse can be the result of simple ignorance, the exercise of poor judgment, or the lack of a clear, relevant standard to govern action in a particular situation.

These distinctions are important to understand as we try to place the Medicaid "fraud and abuse" phenomenon in perspective, for the choice of remedies—and the respective roles, of government, providers, and the general public—can only be made when we understand both the nature and the sources of fraud and abuse. Also, there is growing evidence of a frightening inclination on the part of some prosecutors to abuse the authority of grand juries, elevating to the status of fraud minor financial irregularities which merit civil restitution at most, not criminal prosecution. For discussion purposes, fraud and abuse can be conveniently placed into the categories of (1) unacceptable financial practices; or (2) patient care abuse, including provision of patient services which are unnecessary or inferior in quality. Often the two are related, as when services suffer from diversion of funds or payment is obtained for services not actually performed.

An effective effort directed at fraud and abuse must rely in the long run on systems and procedures which reduce the incentives and the opportunities for subversion of the program by its administrators or constituents. This implies the presence of both positive and negative influences—positive, in the form of adequate resources, efficient program management, clear and concise rules and regulations—negative, in the form of regular, effective monitoring and swift, sure retribution for offenders consistent with due process.

I. FINANCIAL ABUSE

Much of the financial abuse in nursing homes can be traced to faulty methods payment for service coupled with insufficient auditing of financial records of nursing homes. Some of the most common faults which have existed in the payment methods used by some though not all of the state Medicaid program are:

(1) Inadequate rates to support levels of services required by legal standards, and attract sufficient investment capital;

(2) Lack of uniform procedures for collecting cost data to support the rate-making process;

(3) Imprecise definitions of allowable costs which nursing homes may claim;

(4) Inadequate requirements for maintenance of financial records by nursing homes;

(5) Excessive delays in payment for services rendered;

(6) Failure to perform sufficient desk and field audits to verify the accuracy and appropriateness of claims for payment by nursing homes, particularly where payment is made on a cost or cost-related basis.

Federal regulations were issued on July 1, 1971 to implement Section 1902 (a)(13) of the Social Security Act, which requires that Medicaid payments to nursing homes be made on a reasonable cost-related basis. Although these regulations were inexclusably delayed for almost four years, we believe that they now provide the basis for correcting the deficiencies outlined above if properly implemented.[3] Our association worked closely with HEW in the development of these regulations and we are now carefully monitoring their implementation by the States.

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[2] Webster's New Collegiate Dictionary.

Brief comments are in order with respect to the most common examples of financial abuse by nursing homes.

(1) Abuses involving inflation of service costs resulting from self-dealing, kickbacks, or bribes.

There are three principal methods of detecting or discouraging financial abuse where the abuse takes the form of inflated claims resulting from the payment by the provider of higher-than-market prices for supplier and services procured under non-arms'-length arrangements.

(a) Comparison of providers' costs to average or "standard" costs for the same items or services in the open market.[4]

(b) Strict rules for disclosure of ownership and disclosure of arrangements with substantial contractors.

(c) Establishing payment rates prospectively on a standard cost basis or approved budget basis rather than payment of each provider's actual costs on a retrospective basis.

Transactions among parties related by common ownership do not necessarily equate to abuse, and indeed can have the desirable result of increased efficiency and cost savings. Proper safeguards are necessary, to be sure. Kickbacks and bribes are presently illegal under the Federal Medicaid law. (Sec. 1909, Social Security Act.)

(2) Abuse related to depreciation and interest payments on capital assets.

Abuses in the area of mortgage or lease payments can occur where the payment system pay individual facilities capital cost allowances on the basis of overstated property values, higher than necessary construction costs, or luxury accommodations.

Options for minimizing abuse in the property area include:

(a) Disclosure of ownership and financing arrangements;

(b) Use of qualified appraisals to establish fair market value of assets where necessary;

(c) Limitation of depreciation basis to the lesser of (1) fair market value or (2) replacement cost less accumulated depreciation upon transfer of ownership at gain;

(d) Use of construction cost indices or establishment of ceilings on construction costs recognized for purposes of payment of capital expenses;

(e) Ceilings on allowable mortgage interest rates;

(f) Substitution of imputed allowances for actual depreciation, interest, and related capital expenses.

The above options are not mutually exclusive.

Allowances for use of buildings and equipment must be sufficient to permit providers to meet reasonable amortization schedules and provide for the maintenance and replacement of assets. Additionally, owners are entitled to sell their property at a fair gain or enter into bona fide leases. Undue restrictions will drive much-needed capital from the nursing home industry and result in further bed shortages and unnecessary expenditures for costly hospital care.

(3) Mishandling of Patients' Personal Funds

No regulations or policies should be necessary in order for a nursing home provider to know that it is improper to appropriate patients' funds to his personal use. Because of the limited capacity of nursing home residents to manage their own funds, facility administrators assume a fiduciary responsibility which must be exercised with complete fidelity and sensitivity.

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[3] AHCA support of the regulation is qualified to the extent of the delay in their effective date from July 1, 1976 to January 1, 1978 and the language in the explanatory preamble limiting the form of profit factor for nursing homes providers to a return on owners net equity. The regulation itself makes no mention of a profit factor. AHCA's believes that states should be permitted to adopt the forms of profit factor or similar allowance paid in the form of fixed per diem amounts or incentives related to efficient performance.

[4] NOTE.—Establishment of "standard" costs can be accomplished by the aggregation and array of data derived from uniform cost reports, supplemented by marketplace sampling. Some items, such as prescription drugs, fluctuate widely in acquisition cost and are therefore not easily standardized.

The exercise of this responsibility, however, is far more complex than the outsider would imagine. Also, substantial clerical and accounting time and expense is required in order to record the many patient accounts transactions.

Moreover, as the GAO and other investigative bodies have pointed out, Federal regulations and guidelines on this subject are presently inadequate and State procedures are conflicting or non-existent.[5]

HEW's Office of Long-Term Care is presently drafting guidelines to address specific questions concerning the safeguarding and accounting for patients' funds.

The AHCA has asked its Government Services Committee to draft an Association policy statement on this subject which will suggest proper procedures to be followed, including:

(a) Keeping accurate records of funds received and disbursed; reconciling bank and individual bank and individual ledger account balances; avoidance of comingling;

(b) Providing proper receipts to patients and quarterly statements;

(c) Guidelines for authorization of expenditures by patients, family members, or other parties with legal responsibility for the patient;

(d) How to credit interest in individual ledger accounts when funds are placed in interest bearing bank accounts;

(e) Refraining from charging Medicaid for items and services charged to patients' personal funds;

(f) Maintenance of adequate medical justification for charges to patients for medical services or supplies; and

(g) Procedures for transfer of funds to control of new facility owners; handling of funds of deceased or transferred patients.

The proper role of the American Health Care Association and its affiliated state organizations with respect to the financial management of nursing homes will continue to be primarily an educational role. The Association shares some responsibility with the accounting profession for educating its members on proper financial practices and makes a major effort to assist Federal and State policy makers in designing regulations and systems for proper and efficient payment for services. AHCA does not audit its member facilities, nor does it issue or enforce rules in relation to the financial management of nursing homes. These functions are the proper responsibility of state and federal paying and audit agencies. This paper will later discuss possible Association sanctions against its members who are convicted of fraudulent practices.

II. ABUSE RELATED TO SUBSTANDARD CARE

Poor care is often, though not always, associated with financial irregularities. While certain amounts of revenue are necessary to support a proper quality of care, the existence of these revenues does not guarantee that quality care will result. There are many other factors, tangible and intangible. Some are within the realm of the nursing home administrator's control. Other factors such as community and family attitudes, and the degree of involvement of physicians and other outside health professionals, are only partially within the control of the administrator or not at all.

Insofar as externally-defined health and safety standards are concerned, it is widely acknowledged that the state of the art of measuring quality care in precise terms is far from perfect. Much needs to be done to streamline the overlapping bureaucracies at all levels of government which are responsible for various aspects of administration of Medicaid and other health programs. Similarly, the maze of federal, state, and local rules and regulations is suffocating nursing home staff. These need to be reduced in number and rewritten with some consideration for simplifying them and achieving a degree of reciprocity among conflicting authorites such as state and local health departments, fire marshalls, and Federal agencies. Systematic and simplified patient assessment techniques should be refined and applied in order to measure the quality of care actually being received by patients in addition to assessing the facility's capability to render quality care.

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[5] Statement of Gregory J. Ahart, Director, Manpower and Welfare Division, GAO before the Subcommittee on Long-Term Care, Special Committee on Aging, United States Senate, Thursday, Nov. 13, 1975, pp. 3–6.

Notwithstanding these qualifications, clear cases of patient neglect or abuse can be identified with a minimum of observation and investigation. There is simply no excuse for patient neglect or abuse under any circumstances. Deficiencies of lesser severity occasionally result from failure to follow proper medical, nursing, dietary or housekeeping procedures. These can be and are corrected under normal circumstances. These distinctions need to be clearly understood by the public when reading about nursing homes with alleged deficiencies. "Paper" deficiencies related to documentation or reporting requirements can be found in any hospital, nursing home, school or other institution subject to government regulation on any day of the week.

Why are nursing homes (or more frequently boarding houses) with repeated violations of health and safety standards sometimes permitted by licensing bodies to cotinue doing business as usual? We believe the principal reasons are four-fold, in order of importance:

(1) Non-availability of alternate facilities to care for patients;

(2) Insufficient funds allotted to assuring adequate numbers of well-trained inspectors;

(3) Lack of proper procedures in many states for resolving questions concerning the certification status of facilities with deficiencies, and

(4) Direct subversion of the licensure and inspection functions through bribes or political interference.

Items 1 and 2 can be directly laid to conscious budgetary decisions by states to hold the line on burgeoning Medicaid expenditures. Item 3 should be corrected by enacting Federal legislation specifying minimum requirements for timely due process hearings as conditions for approval of state Medicaid plans. AHCA submitted proposed amendments to the Senate Finance Committee's Subcommittee on Health on July 30, 1976 during hearings on S. 3205.[6] Essentially, the amendments would require states to expedite certification hearings prior to termination of Medicaid agreements with nursing homes. An exception would be permitted where there is a finding that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients. Under the circumstances, authorities would be empowered to take immediate protective action.

Item 4 is the proper concern of state and local law enforcement bodies.

Primary responsibility rests with state licensure and decertification authorities to enforce health and safety standards in nursing homes and other health institutions. That is where legal authority and police power resides in this country.

What then is the responsibility of the nursing home profession in relation to the quality of care rendered in nursing homes?

Role of AHCA in Assuring Quality Care

AHCA represents about half of the licensed, long-term care facilities in the nation. It is the nation's largest nursing home organization. Membership in AHCA and its predecessor, the American Nursing Home Association, has grown rapidly during the last five years. This has occurred because more and more owners, sponsors, and administrators have recognized the great necessity for collective action toward self-improvement and toward influencing the course of public policy. AHCA membership offers many important professional, educational, and economic benefits to its members, and contributes substantially to the public interest and the welfare and well-being of infirm elderly Americans.

In exchange for the benefits of association membership, the individual member owes the group more than mere financial support. The group has the right to expect the individual member to adhere to the Code of Ethics, to conscientiously pursue the highest standards of patient care, and to participate willingly and actively in activities designed to enhance his own knowledge and expertise and to improve the profession.

We are proud to say that the overwhelming majority of our members are performing these responsibilities and performing them well! It must be conceded, however, that the few who do not measure up are a major embarrassment. With more than 15,000 licensed nursing homes in the nation, there perhaps will always be those whose actions reflect adversely on the profession, and more importantly, are a disservice to those entrusted to their care. They should not find safe haven in their professional association.

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[6] See testimony of Bruce D. Thevenot on behalf of AHCA, Hearings on Medicare-Medicaid Administrative and Reimbursement Reform, Subcommittee on Health, Committee on Finance, United States Senate, p. 395.

AHCA and its state affiliates have an obligation to establish mechanisms to screen unqualified members, resolve complaints, and terminate membership of those found guilty of illegal actions or who fail to correct serious deficiencies.

AHCA's Peer Review program is presently in place in 29 of our 49 state associations. The remaining 20 affiliates are required to have an approval program no later than December 31, 1978. While it provides a means of self-help and consultation as well as a method of resolving complaints, we need to take further steps to strengthen Peer Review. Additionally, we need a carefully-conceived mechanism for considering the membership status and privileges of those convicted of criminal offenses or those who repeatedly fail to meet proper standards of care. Accordingly, President Theodore Carcich, Jr. is today making the following recommendations to the Association.

Recommendations

(1) The AHCA Task Force on Peer Review has been asked to draft and present to the Executive Board and Governing Council its suggestions for making it mandatory that state association Peer Review committees institute prior screening and approval of all new membership applications. Preadmission review is currently optional.

(2) The Constitution and By-Laws Committee and legal counsel have been directed to draft and present to the Executive Board and Governing Council their recommendations for the creation of an authority and proper procedures for effecting the permanent or temporary suspension from participation in the state and national associations of persons convicted of criminal offenses or for other good cause.

(3) That Peer Review approval be made a prerequisite for holding elected or appointed office in the National and State Associations.

It is expected that these and other finalized proposals can be laid before the House of Delegates for ratification at the 1977 Fall convention in San Diego.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., January 31, 1977

Hon. CLAUDE PEPPER,
Chairman, Select Committee on Aging,
Subcommittee on Health and Long-Term Care,
House of Representatives.

DEAR MR. CHAIRMAN: This is in response to your request for our opinion concerning the effect of regulations issued by the Department of Health, Education, and Welfare (HEW), implementing section 249(a) of Pub. L. No. 92–603 (October 30, 1972), 86 Stat. 1381.

You request our opinion on three specific questions.

(1) By providing for a further delay in the implementation of the effective date of Section 249 of Public Law 92–603, is the Department of Health, Education and Welfare in compliance with the statute?

(2) Under what authority does the Secretary of Health, Education and Welfare have the power to delay implementation beyond the effective date of the enactment without Congressional approval?

(3) What steps are available to the Congress (or to the Comptroller General) to ensure that its mandates for action on this enactment will be implemented forthwith?

HEW's authority for the Medicaid program is set forth in title XIX of the Social Security Act, as amended, 42 U.S.C. § 1396 et seq. The pertinent portion of this authority follows:

"* * * The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance." 42 U.S.C. § 1396 (1970).

The States are responsible for meeting the statutory requirements for State plans set forth in section 1902 of the Social Security Act, 42 U.S.C. § 139a.

That section was amended by section 249(a) of Pub. L. No. 92–603, supra, by the addition of a new subsection (a)(13)(E). As amended, that subsection now states that:

"A State plan for medical assistance must—

* * * * * * *

"(13) provide—

* * * * * * *

"(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary."

This section does not by its terms place any requirement on HEW other than to approve and verify cost finding methods adopted by the States. Under 42 U.S.C. § 1302 (1970) the Secretary is required to issue such regulations under the Social Security Act "* * * as may be necessary to the efficient administration of the functions * * *" with which he is charged. Regulations (45 C.F.R. § 250.30) concerning reimbursement methods for skilled nursing and intermediate care facilities under prior law had been issued by HEW prior to the enactment of Public Law No. 92–603. These regulations remained in force until amended by the regulations of July 1, 1976. The regulations of July 1, 1976, provided the following time frames for State compliance with section 249(a):

45 C.F.R. § 250.30 (a)(3)(i)A states:

"* * * the State plan shall:

"(A) Specify the inclusive dates of the cost reporting year under this section, which year need not be the same for all providers of long term care facility services under the plan; and specify the beginning date of the first such cost reporting year, which shall be no later than January 1, 1977;"

45 C.F.R. § 250.30(a)(3)(iv) provides:

"(iv) The State plan shall set forth the methods and standards used by the State to determine reasonable cost-related payment rates, and shall set payment rates on the basis of such methods and standards, to be effective no later than January 1, 1978. * * *"

In response to our request for comments, the Acting Secretary of HEW provided us with the following statement of HEW's position with respect to your first two questions:

"The answer to your first two questions is that the Secretary has no authority to delay implementation of a statute beyond its effective date. However, the Department does not believe that it has done so, but rather believes that it is in compliance with its statutory obligations with respect to his matter.

* * * * * * *

"Section 1904 of the Act sets forth the only statutory remedy available to the Secretary in the event of a State's noncompliance with a State plan requirement under Medicaid. Under section 1904, if the Secretary, after giving the State reasonable notice and opportunity for hearing, finds either that the State plan does not comply with the provisions of section 1902 of the Act, or that the State, in its administration of the plan, fails to comply substantially with its plan, he has the authority to end Federal financial participation in the nonconforming portion of the State's program or, in his discretion, to terminate the State's participation in the Medicaid program. The courts have uniformly held that use of this remedy is discretionary with the Secretary. *Rosado* v. *Wyman*, 397 U.S. 397 (1970), *National Welfare Rights Org.* v. *Finch*, 429 F. 2d 725 (D.C. Cir., 1970).

"In light of the difficulty that we recognize confronts some States in developing the cost-finding methodology and cost data on which to base reasonable cost-related reimbursement rates, the Secretary committed himself in the regulations not to exercise the discretion provided him by section 1904 before January 1, 1978, against any State which met the timetable specified in the regulations discourages the States from implementing the statute immediately. In fact, the same passage of the preamble quoted in your letter goes on to say:

'"The States are encouraged to meet each requirement of the regulations as soon as possible.'

"In short, the Department has not 'provided for a further delay in the implementation of the effective date of Section 249,' as is assumed by your first question quoted above. The Department has, rather, committed itself, for a limited time, not to impose on the States a particular sanction entirely within its discretion. This decision does not change the effective date of the statute."

We do not agree with the views expressed by the Action Secretary. We read the regulations of July 1 as specifically providing for a further delay in the need for State plans to conform to the reimbursement requirements of section 249.

We find, as the Acting Secretary seems to have found, that the statutory language of section 249 is plain on its face. The legislative history, although scant, is fully in accord with our reading. Section 249 by its terms makes subsection (a)(13)(E) effective July 1, 1976, nearly 4 years after enactment of Pub. L. No. 92–603 (October 30, 1972). The words of the statute are unmistakable: "(a) A state plan for medical assistance must— * * * (13) provide * * * (E) effective July 1, 1976 * * *." This language establishes that which comes after as a mandatory requirement for State plans as of July 1, 1976. In this regard we note that both the Senate Report that explained this Senate Amendment to H.R. 1 (S. Rep. No. 92–1230, 92d Cong., 2d Sess. 287, (1972)) and the Report of the Conference Committee (H.R. Rep. No. 92–1605, 92d Cong., 2d Sess. 56 (1972)), that adopted the Senate Amendment describe that Amendment as follows:

"[Section 249] * * * would require States to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis *by* July 1, 1974." (Emphasis supplied.)

The Conference Committee, *id.*, added 2 years to the effective date of this provision.

Agencies have no authority to issue regulations that conflict with the statutory requirements under which they are issued. HEW's authority to issue Social Security regulations under 42 U.S.C. § 1302 (1970) is tested by whether they are, "reasonably related to the purpose of the enabling legislation," *Johnson's Professional Nursing Home* v. *Weinberger*, 490 F.2d 841, 844 (5th Cir. 1974). The statutory language places a clear burden on the States to be in conformity with 42 U.S.C. § 139a(a)(13)(E) by July 1, 1976, and failure to comply therewith cannot be excused by HEW through regulations.

In its report to us, HEW takes the position, quoted, that it is merely exercising its discretion not to take compliance action under section 1904 of the Social Security Act, 42 U.S.C. § 1396c (1970), and that it is not discouraging the States from implementing the statute immediately. It seems clear from the regulations quoted above that rather than indicate a decision not to initiate enforcement procedures against States not meeting the statutory deadline, the regulations purport to relieve the States of the burden of complying with the statute as long as they are in compliance no later than January 1, 1978. HEW does not, in our view, have authority to waive a statutory deadline by regulation.

"We conclude, therefore, that the expressions in the regulations of July 1, 1976, further postponing the date upon which States will be required to meet the provisions of 42 U.S.C. § 1396a(a)(13)(E) are contrary to the provisions of that statute in so far as they purport to relieve the States from the requirements of providing reasonable cost related reimbursement to skilled nursing and intermediate care facilities. Accordingly, our answer to your questions 1 and 2 are that the Secretary of HEW has no authority to delay the implementation of section 249 of Pub. L. No. 92–603 beyond July 1, 1976, and that those portions of the regulations of July 1, 1976, that purport to postpone the date upon which State plans must conform to 42 U.S.C. § 1396a are contrary to the statute."

With respect to question 3 concerning the steps available to Congress (or the Comptroller General) to ensure that section 249 is implemented forthwith, we see little remedial value for the Comptroller General to take exception to payments to States who have not complied with the statute but are following HEW's announced timetable for compliance. An exception would only serve to reduce the Federal payments going to the State and ultimately would impact upon the patients and the providers that you suggest may be suffering financial loss in the absence of a cost related reimbursement system. Since an exception on our part would not cure the problem by expediting compliance, we do not believe that such an action would carry out the overriding intent of the Congress to provide eligible beneficiaries with skilled nursing and intermediate care facilities. Similarly, if we recommend that HEW take immediate steps to exercise the statutory sanctions it has available for noncompliance with Medicaid requirements for State plans, the State program will suffer and there will still be no increase in reimbursement entitlements to skilled nursing or intermediate care facilities, because that can only come about through adoption in the State plan of sound methods and standards for cost reimbursement which must then be approved and verified by HEW.

In short, the delay in implementing the statute has already occurred, and some States do need more time to convert their present cost reimbursement methods. As a practical matter, an 18 month period of lead time may be essential for such States to turn in a good plan, in view of the program requirements to hold public hearings, develop reporting formats, hire new staff, etc. We see no useful purpose in taking any punitive steps that will reduce Federal payments to States and ultimately impact on patients. Such steps are not likely to speed up the process of preparing the new State plan appreciably.

Sincerely yours,

R. F. Keller,
Deputy Comptroller General of the United States.

Mr. Rogers (presiding). Thank you very much.

STATEMENT OF RENE I. JAHIEL, M.D.

Dr. Jahiel. My name is Rene Jahiel. I am a physician and a professor of community medicine at New York University School of Medicine. I appear today as a member of the board of directors for the Citizens for Nursing Home Reform.

The Citizens for Nursing Home Reform is a nonprofit organization of individuals in New York City who are concerned with patient abuse in nursing homes and with the care of the elderly in the community.

My testimony will be limited to discussing the suspension of practitioners for fraud or abuse such as giving services in excess of the need of the individual, harmful to the individual, or of grossly inferior quality.

A potentially effective fiscal leverage to protect the public against such abuses is the legal right to suspend physicians or other practitioners from participation in medicare or medicaid programs for an appropriate period of time or to terminate agreements with institutional providers of services.

However, there are many instances when the practitioners or institutional providers who commit such abuses are the only ones in the area who are accessible to individuals dependent upon medicare or medicaid.

In such instances, either of the following would happen:

One: The practitioner or institutional provider might be suspended and the people who depend upon their services might find themselves without a local supply of such services; or

Two: The authorities responsible for enforcing suspension provisions might tend to lower their standards for quality of care, or make use of very short periods of suspension, so that the errant practitioner or institution continues to provide services with no or little interruption.

To resolve this dilemma, we are making the following recommendations:

One: Physicians, other practitioners, or provider institutions who have committed fraud or who have repeatedly given services in excess of the needs of the individual, harmful to the individual, or of a grossly inferior quality, should be suspended from participation in title 18 or 19 for a period of time adequate to insure that such abuses will not recur.

Two: Whenever such suspension would leave a population which is dependent upon medicare and/or medicaid services without access to such services, as determined on the basis of regulations to be established by the Secretary of HEW, such population shall be considered to fulfill the requirements of a health manpower shortage area as defined in the Public Health Services Act, amended by Public Law 94-484, and physicians or other practitioners from the National Health Service Corps shall be assigned, together with necessary support personnel, to provide services for such population, until such time that medicaid and medicare services of adequate quality, safety, and volume can again be supplied locally to such populations.

Three: Legislation concerning Veterans Administration or Armed Forces Medical Services should be amended so that, if such medicaid-medicare underserved areas is located near a Veterans Administration hospital or an Armed Forces medical facility, such Federal hospitals or medical facilities would contribute physicians, other practitioners, or institutional services in lieu of the National Health Service Corps. if that would represent a more efficient solution to the local humanpower problem.

We are also recommending that the same approach be used to provide services in areas where there are not enough medicaid- or medicare-participating physicians, practitioners, or provider facilities to fulfill the needs of that population which is dependent upon medicare and/or medicaid for its health care services.

In summary, we propose changes in the appropriate laws to the effect that when there are not enough medicaid- and/or medicare-participating practitioners or provider institutions to fulfill the needs of people dependent upon medicaid or medicare for their services, or when suspenson of a practitioner or provider institution from participation in medicare or medicaid would leave the population that depends upon medicare and/or medicaid services in that area underserved, the Federal Government shall assign without delay practitioners and support personnel to that area from: (a) The National Health Service Corps; (b) the Veterans Administration hospitals; or (c) Armed Forces medical facilities in the region, to provide services in that area until adequate services can again be provided by local practitioners or institutions.

Thank you.

Mr. Rogers. Thank you very much, Mr. Jahiel. We appreciate it.

Mr. Crowley.

STATEMENT OF DAVID C. CROWLEY

Mr. Crowley. Mr. Chairman, members of the committee, I am David C. Crowley. I am the executive vice president of the American Association of Homes for the Aging.

I have a brief statement, but I would respectfully request that it be read into the record.

Mr. Rogers. The statement will be made part of the record.

Mr. Crowley. The American Association of Homes for the Aging represents the not-for-profit providers of institutional services to older Americans and their residents.

Among our members are facilities which participate in the title XVIII, medicare, program as skilled nursing facilities and in the title XIX, medicaid, program as skilled nursing facilities and intermediate care facilities.

Accompanying me this afternoon is Laurence F. Lane, who is director for public policy of our national office.

At the outset, allow us to stress that our association is pleased that this committee has initiated legislative reforms to improve the performance of the medicare and medicaid programs. The common denominator that binds our membership together in strengthening the not-for-profit sponsorship of institutional services, ranging from basic housing through skilled nursing care, is a commitment to providing quality services to older Americans.

My testimony this afternoon will take the flavor of pointing out some of the concerns we have of how that impacts upon the patients or the residents themselves.

While our association is generally supportive of the amendments contained in H.R. 3, we temper our enthusiasm with a caution that Congress must be continually vigilant that its actions do not impact detrimentally upon the older person in whose interest we are acting.

Actions which reinforce the medical emphasis of the medicare and medicaid programs may restrict the eligibility of the older person to receive the benefit. Directions which confuse the policy instruments of medicare and medicaid to focus solely on the service needs of the acute, episodic patient population impact negatively upon the chronically ill, long-term patient.

One cannot overemphasize that long-term care facilities are reimbursed under the law for the provision of services to two differing patient populations and that administrative reforms should account for the differing needs.

The above caution is of particular importance with the committee consideration of section 5 of H.R. 3 concerning the clarification and strengthening of the role of the PSRO program.

Our Association has been supportive of the Department's efforts to develop criteria for PSRO review in long-term care facilities; however, we were most disappointed with the guidelines promulgated by the Bureau of Quality Assurance for such review.

In many cases these guidelines are written by practitioners in the hospital field who are attempting to put hospital standards on the long-term care facilities.

The committee may wish not to consider amending the PSRO program as a part of this legislative package but to follow the suggestion of Senator Talmadge who deleted this section from his otherwise identical legislation.

With respect to the this consideration, and related to the committee's discussion of uniformity in the medicare and medicaid program, we call to your attention a recent study prepared by the Community Research Applications Corp. under a Health Services Administration contract, entitled "A National Study of Levels of Care in Intermediate Care Facilities."

What this report concluded was there is no systematic method of patient classification and until one is developed, would be inappropriate to revise the type and standards for intermediate care.

We express similar caution with respect to the committee's consideration of amendments to speed the implementation of the national goal for uniform cost accounting as called for in section 1502 of Public Law 93–641.

While the logic of forcing actions to improve the data collection abilities of both the Federal and State agencies cannot be faulted, haste might have a detrimental effect upon the institutionalized.

We point out that the size and relationship to other health facilities are factors that must be considered.

As Mr. Brewer pointed out, we are concerned, also, about the delayed implementation of section 249 regulations. If we are going to have quality care, we have to move forward on the implementation of this cost-related reimbursement regulation.

We would draw attention, too, Mr. Chairman, to the implementation of current fraud and abuse procedures. There has been an increasing trend to focus on the process rather than the patient resident.

For instance, the recent HEW publication of the Results of the Medicaid Provider Review, Massachusetts confesses in its lead paragraph, "the Medicaid Examiner Review is a service verification process * * *. The reviews are not designed to evaluate the quality of medical care delivery by a provider * * *."

We are concerned about how that affects the care for the older person.

The Moreland Act Commission found that only 30 of 526 items used by the survey inspection report actually had anything to do with direct observation of the patients.

With respect to section 11 of H.R. 3, we are concerned that there might be an unintended result of forcing all skilled nursing facilities to be participating providers under medicare before being eligible for participation under medicaid.

Again, we would like to emphasize that efforts to unify long-term care policies and procedures under the two programs must address the differing focus of the primary responsibilities.

We run the risk of having a single policy instrument to address two different patient needs with the end result being an emphasis on the requirements to meet acute episodic illness.

We urge the committee to defer action on section 11 until such time as a review is made of the benefit package and its restrictive elements.

Without taking away from the immediacy of the first steps which this committee has embarked upon, should it be your desire to truly impact upon the delivery of services in long-term care facilities and to upgrade the quality of such services, then the recommendations outlined in our text should be considered.

We appreciate this opportunity to appear before the committee.
[The prepared statement follows:]

STATEMENT OF DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

I am David C. Crowley, Executive Vice President of the American Association of Homes for the Aging. The American Association of Homes for the Aging represents the not-for-profit providers of institutional services to older Americans and their residents. Among our members are facilities which participate in the Title XVIII (Medicare) program as skilled nursing facilities and in the Title XIX (Medicaid) program as skilled nursing facilities and intermediate care facilities. Accompanyng me this afternoon is Laurence F. Lane, who is Director for Public Policy of our national staff.

At the outset, allow us to stress that our Association is pleased that this committee has initiated legislative reforms to improve the performance of the Medicare and Medicaid programs. The common denominator that binds our membership together in strengthening the not-for-profit sponsorship of institutional services (ranging from basic housing through skilled nursing care), is a commitment to providing quality services to older Americans. We share the underlying consensus of the public that the Federal government has been a very poor purchaser of services through the Medicare and Medicaid program, and that reforms are required.[1]

While we shall focus our statement on the amendments before us specifically addressing program administration, we cannot over emphasize that further committee consideration must be given to improving the responsiveness of the Medicare benefit package to the needs of the elderly to standardizing the eligibility and benefit criteria of the Medicaid program, and to the development of a comprehensive program addressing the delivery of long-term care services to the elderly. We are heartened by the Chairman's introductory statements that this will be the first of a series of Congressional initiatives in this area.

While our Association is generally supportive of the amendments contained in H.R. 3, we temper our enthusiasm with a caution that Congress must be continually vigilant that its actions do not impact detrimentally upon the older person in whose interest we are acting.[2] Actions which reinforce the medical emphasis of the Medicare and Medicaid programs may restrict the eligibility of the older person to receive the benefit. Directions which confuse the policy instruments of Medicare and Medicaid to focus solely on the service needs of the acute, episodic patient population impact negatively upon the chronically ill, long-term patient. One cannot over emphasize that long-term care facilities are reimbursed under the law for the provision of services to two differing patient populations, and, that administrative reforms should account for the differing needs.

The above caution is of particular importance with the Committee consideration of Section 5 of H.R. 3, concerning the clarification and strengthening of the role of the PSRO program. Our Association has been supportive of the Department's efforts to develop criteria for PSRO review in long-term care facilities; however, we were most disappointed with the guidelines promulgated by the Bureau of Quality Assurance for such review. A clear and present danger lies in the lack of knowledge and the habitual lack of attention to the conditions and the interaction of conditions which are peculiar to the aged and which create long term care needs; and, in the tendency to fill this vacuum with the simple transference of methods, rules and norms from the familiar ground of hospital practice. The promise that a realistic application of PSRO standards will bring an approach which emphasizes combinations of services to promote maintenance of health and maximum functioning for the patient appears to have been missed by the proposed guidelines. Our members have consistently observed that the application of the principles of a medical model overlook the essential needs of the long-term care patient.[3] The Committee might wish to reconsider amending the PSRO program as a part of this legislative package, and, to follow the suggestion of Senator Talmadge who deleted this section from his otherwise identical legislation.

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[1] For a further discussion of our Association's position with respect to fraud and abuse see: U.S. Government, Department of Health, Education and Welfare, "Do Nursing Homes Deserve the Heat They're Getting?", *The Social and Rehabilitation Record,* December-January 1977.

[2] In testimony presented by the National Retired Teachers Association and the American Association of Retired Persons to the Senate Finance Committee concerning the provisions of S 3205 (94th Congress), it was stated: (July 30, 1976)

"The consumer is placed in a real dilemma in responding to the need for tighter administrative controls in the reimbursement programs. On the one hand, we are wary of advocating reimbursement controls inasmuch as they often translate out in the long run to reductions in benefits while on the other we are shocked by the continued inefficiencies tolerated. Congressional oversight will be necessary as we walk the line between providing necessary services to eligible recipients while constraining unwarrented costs. We can point to several General Accounting Office studies that clearly indicate that when the Bureau of Health Insurance attempted to contain costs there has been a general overreaction that generated a series of retroactive denials and reductions in benefits to recipients. It appears that attempts to improve efficiency often provoke difficulties in the translation of program goals."

Should the committee conclude that immediate, remedial steps must be taken with respect to the PSRO program, we would encourage attention to three important program aspects: (1) strengthened nonphysician involvement in the development of PSRO's formal plans for long term care review; (2) statutory direction to provide representation on the national advisory council for Professional Standards Review Organizations to individuals who can reflect an understanding of and appreciation for the special health problems of older Americans; and (3) recognition of the unique transition from the present utilization review requirements to the PSRO review process that must be made by long term care service providers.

With respect to the third consideration, and related to the committee's discussion of uniformity in the Medicare and Medicaid program, we call to your attention to a recent study prepared by the Community Research Applications Corporation under a Health Services Administration contract, entitled: *A National Study of Levels of Care in Intermediate Care Facilities*. The report conclusion is most direct:

> Until such time as a systematic method of patient classification and assignment to long-term care is developed, it makes little sense to modify existing Federal regulations. Impairment of patients classified as in need of ICF care should be equivalent across all states. Once it is clear who is in ICF's, it will make sense to develop national standards and regulations regarding the type and quantity of services which should be rendered.[4]

In essence, this study provides a strong rationale for Congressional consideration of the broad issues of entitlement and benefit coverage before attempting to patchquilt administrative reform, at least with respect to the intermediate care facility population. Data provided indicates that assignment to ICFs and the level of care provided within ICFs is so widely variant across states as to preclude any attempt to develop generalized statements as to services being provided.[5] One must question how a PSRO program modeled upon a hospital delivery system can bring rationality to the provision of services without a prior clarification of what services and who should be entitled to those services is completed.

The unintended results of consistent Congressional emphasis on the long-term care delivery system within the context of a medical entitlement are twofold: (1) facilities are increasingly becoming mini-hospitals ignoring the social components necessary for life quality of the institutionalized and (2) individuals are being denied entitlement to program benefits in massive reclassification of patient/residents. A PSRO program with absolute control of placement has the potential of seriously restricting the program benefit.

Similar caution must be expressed with respect to the Committee's consideration of amendments to speed the implementation of the national goal for uniform cost accounting as called for in Section 1502, of Public Law 93–641. While the logic of forcing actions to improve the data collection abilities of both the Federal and state agencies cannot be faulted, haste might have a detrimental affect upon the institutionalized. Our Association has cooperated during the past year in a Health Resources Administration grant to the Battelle Human Affairs Research centers focusing on Cost Data Reporting System for Nursing Home Care.[6] While our first finding that there is a widespread variation both across facilities and states in accounting and recording practices is hardly statrling, the facts indicate that the many variables which must be considered with respect to meeting patient/resident needs preclude an easy transistion to a uniform accounting system. Among the factors that must be carefully reviewed will be the numerous instances, especially in non-profit sponsored facilities, where residential facility is linked to the licensed, participating SNF/ICF facility. Likewise, size and relationship to other health facilities are factors that must be considered.[7]

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[3] For additional detail see: Letter of November 11, 1976 from David C. Crowley to Dr. Michael J. Goran commenting on the proposed guidelines by the Bureau of Quality Assurance for PSRO Review of Long Term Care.

[4] Community Research Applications, Inc., *A National Study of Levels of Care in Intermediate Care Facilities,* Prepared for Health Services Administration, DHEW, under contract number: HSA–105–74–176, April, 1976.

[5] *Ibid.* Chapter IV.

We urge the committee to defer action on requirements to expedite uniform cost accounting for long-term care facilities. This is not to oppose movement toward such a system, but to request that the committee carefully deliberate the impact of such steps upon the delivery system. A strong argument can be advanced that uniformity might have a negative impact upon those providers who are setting the yardstick of quality care. In some states which are implementing uniform cost accounting in conjunction with the Section 249 requirement for reasonable-cost related reimbursement, class groupings are being used to impose maximums on the intensity and quality of services purchased while other aspects of the in tandam effect of these requirements is to condone mediocre care at the lowest common denominator. In essence, we might be encouraging a system that provides continued disincentives to good care and penalizes quality care.

Inasmuch as we have mentioned Section 249, please allow me to digress a moment to urge that this committee focus on the failure of the Department to implement cost-related reimbursement under the Medicaid program within the timeframe required by Public Law 92–603. As you know, Congressman Pepper, Chairman of the House Select Committee on Aging, wrote the Comptroller General in September, 1977, asking for his opinion on whether the Secretary of Health, Education and Welfare was in compliance with the statute by providing for a delay in the implementation of the effective date of Section 249.[8] In a response, dated January 31, 1977, the Comptroller General stated:

"We conclude, therefore, that the expressions in the regulations of July 1, 1976, further postponing the date upon which States will be required to meet the provisions of 42 U.S.C. §1396(a)(13)(E) are contrary to the provisions of that statute in so far as they purport to relieve the States from the requirements of providing reasonable cost related reimbursement to skilled nursing and intermediate care facilities. Accordingly, our answer to your questions 1 and 2 are that the Secretary of HEW has no authority to delay the implementation of Section 249 of Pub. L. No. 92–603 beyond July 1, 1976, and that those portions of the regulations of July 1, 1976 that purport to postpone the date upon which State plans must conform to 42 U.S.C. §1396a are contrary to the statute." [9]

Certainly, this committee should make sure that states are not taking advantage of the delayed implementation, which is contrary to law, to continue inadequate reimbursement for services in SNFs and ICFs. The new Secretary of Health, Education and Welfare should be asked to bring the Department into compliance with the statute immediately.

Returning to the amendments under review, our Association would encourage the members of this committee to be mindful of the implementation of current fraud and abuse procedures. There has been an ever increasing trend to focus on the process rather than the patient/resident. For instance, the recent HEW publication of the Results of Medicaid Provider Review—Massachusetts, confesses in its lead paragraphs:

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[6] Health Care Study Center, Battelle Human Affairs Research Centers, *Cost Data Reporting System for Nursing Home Care,* Prepared for the Long Term Care Division, National Center for Health Services Research, Health Resources Administration, DHEW, under grants numbers HS01114–01A1 and HS01115–01A1, September 1976.

[7] *Ibid,* Executive Summary, pages 6–8.

[8] Letter of U.S. Representative Claude Pepper, Chairman House Select Committee on Aging, Subcommittee on Health and Long Term Care to the Honorable Elmer B. Staats, Comptroller General, General Accounting Office, September 24, 1976.

[9] Letter from the Deputy Comptroller General of the United States to the Honorable Claude Pepper, January 31, 1977—letter reference number B–164031(3).125.

"The Medicaid Examiner review is a service verification process. * * * The reviews are not designed to evaluate the quality of medical care delivery by a provider . . .[10]

While the process is important, let us not neglect the quality of the service provided. One of the key observations of the New York State Moreland Act Commission was:

"The survey inspections concentrate on the written word and can be passed largely by 'paper compliance.' Thus of the 526 identifiable items in the 68-page Federal skilled nursing home survey inspection report, the Commission's review indicates that 290 items can be answered by the surveyor exclusively with reference to written plans, policies and records. In the Commission's view, only 30 of the 526 items might require direct observation of patients."[11]

From the perspective of the provider attempting to deliver quality care, there can be diminishing returns through over-regulation. Time spent meeting paper requirements is time taken away from the resident. We urge the members of this committee to be mindful of the potential for negatively impacting upon the quality providers in the effort to rid the program of the less than scrupulous.

With respect to the latter, our Association wholeheartedly endorses the intent of H.R. 3 to eliminate from the Medicare and Medicaid programs providers who are fraudulent and to prevent abusive practices. Certainly, steps to identify ownership and to increase penalties are a necessary action. AAHA has long advocated such reforms as part of the Medicare and Medicaid program. Encouraging and facilitating the exchange of information among programs and governmental review agencies should be a helpful step. Of course, we would urge that careful safeguards be taken to protect the civil liberties of the beneficiary.

We ask the committee to seriously review the ramifications of establishing too many layers of administrative oversight in the attempt to protect the public from abusive practices. While there is merit in supporting and strengthening the abilities of the states to detect and correct fraudulent behavior fragmented investigations certainly are no safeguard. Before initiating amendments to stimulate Special Prosecutors' Offices, consideration should be given to how these offices will interface with efforts already underway through the Nursing Home Ombudsman Program of the Administration on Aging and through the recently established HEW Office of Insepctor General.[12]

We are concerned that Section 11 of H.R. 3 might have an unintended result of forcing all skilled nursing facilities to be participating providers under Medicare before being eligble for partcipation under Medicaid. It cannot be over-emphasized that any Congressional effort to unify long-term care policies and procedures under the two programs must address the differing focus of primary responsibilities. Again, we run the risk of having a single policy instrument to address twod iffering patient needs with the end result being an emphasis on the requirements to meet acute, episodic illness. Should the committee really wish to address this issue, it must first look at the benefit package and grapple with the restrictive durational limitations and prior hospitalization requirements One particular obstacle that should be changed is the negative impact of the "spell-of-illness" restriction upon the entitlement of a Medicare beneficiary in a facility which provides both skilled and intermediate care services.[13] We would urge the committee to defer action on Section 11 until such time as a review is made of the benefit package and its restrictive elements.

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[10] U.S. Department of Health, Education and Welfare, *Results of Medicaid Provider Review—Massachusetts,* Social and Rehabilitation Service, Medical Services Administration, February 1977, p. 3.

[11] Report of the New York State Moreland Act Commission, *Regulating Nursing Home Care: The Paper Tigers,* New York State Moreland Act Commission on Nursing Homes and Residential Facilities, October 1975, p. 11.

[12] For a further discussion of AAHA's views with respect to the Nursing Home Ombudsman Program see the statement presented for the hearing record of the Administration on Aging public review of the Ombudsman program, November 30, 1976, Boston, MA.

[13] Senator Eagleton sponsored S 1759 during the 94th Congress. This amendment was identical to one offered by Senator Eagleton and others on the Senate floor during the debate of the Social Security Amendments of 1973 (H.R. 3153). While the amendment to lessen the impact of the spell-of-illness requirement was passed by the Senate, it was not among the amendments accepted in Conference. The problem is particularly acute in areas where facilities are duel licensed skilled nursing (SNF) and intermediate care (ICF). Rural areas, and areas with high percentages of multiple short-stay hospitalizations, are particularly hard hit.

Earlier in this statement, we mentioned the Community Research Applications study of the intermediate care facilities program Chapter Five of this study offers an interesting comparison of Federal and state standards for the ICF benefit. It concludes:

"This information suggests that there are at least three problems associated with the standards as they currently exist. First, they lack sufficient operational detail, so that wide latitude remains for local interpretation. Second, even if there existed uniform, operationally-specific regulations, these would be of little value unless all surveyors are trained, in uniform fashion, as to their use. Currently, there is considerable variation in the nature of deficiencies recorded, as a function of different approaches and orientations of different surveyors. Third, as discussed in this report, all such changes will be meaningless unless they are preceded by the development of a uniform approach to a patient screening and assignment to different levels of care.[14]

Without taking away from the immediacy of the first steps which this committee has embarked upon, should it be your desire to truly impact upon the delivery of services in long-term care facilities and to upgrade the quality of such services, then the above recommendation should be considered.

We appreciate this opportunity to appear before the committee.

Mr. Rogers. Thank you, Mr. Crowley.

We will be in touch with you to see if there are any particular ideas that you do have.

Dr. Jahiel, I think your idea of using the National Health Service Corps for areas of critical shortage, if a medicaid mill is closed in a particular area, and there is no doctor left, then certainly we should be able to call upon that National Health Service Corps to provide doctors. I think that is a very good suggestion.

Thank you so much for being here.

Mr. Geoghegan, it is good to see you.

Any questions?

Mr. Carter. Yes, sir.

Mr. Rogers. Dr. Carter?

Mr. Carter. Gentlemen, you represent the nursing home industry, I believe, in our country; is that correct?

Mr. Brewer. Yes, sir.

Mr. Geoghegan. Are you addressing that to me?

Mr. Carter. Yes, Do you represent the nursing home industry in our country?

Mr. Geoghegan. Yes, we do.

Mr. Carter. Have you noticed in your group there's been on many occasions a relationship between nursing home administrators and pharmacists?

Mr. Geoghegan. I can't answer that based upon by own experience. I think Mr. Brewer would be better equipped to respond to that question, sir.

Mr. Brewer. Yes. All nursing homes of necessity have some relationships with pharmacists. Some of these dealings have been unethical in previous years.

Mr. Carter. Are either of you from California?

Mr. Brewer. No.

Mr. Carter. I believe there that this abuse is said to have been quite widespread. I believe that 63 percent of the pharmacists said that it did exist.

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[14] Community Research Applications, Inc. *op. cit.*, Chapter V, p. 43.

I am informed further that recipients of security—supplemental security income, these are usually medicare patients who draw small amounts, are forced to yield this amount to nursing homes in some instances.

Are you aware of this, that this happens in the industry?

Mr. CROWLEY. Mr. Lane would like to respond to that, Dr. Carter.

Mr. LANE. I believe, Dr. Carter, if you are referring to the problem of patient funds, the GAO has done a very extensive survey on the abuse in the patient fund area. This has been a problem. I know we have been working with our members to make sure that there was a clear understanding of the directions given.

I have seen recently some HEW regional memorandums outlining the rights of the patient/resident to assist administrator's in their understanding. Specifically the instructions stated that service charges and items used within the title 19 personal fund area would be safeguarded.

Mr. CARTER. The medicare patient who stays in one of your facilities 100 days and still needs nursing home care; what do you do with that patient?

Mr. THEVENOT. Doctor Carter, if I might respond to that.

I think it statistically is a rare occurrence when that full 100 days is used.

In most cases the fiscal intermediary will have determined prior to that time that the condition of the patient no longer merits coverage.

But to directly answer your question, in any case the patient then has to rely on his or her own resources; or if those resources are sufficiently depleted, then the medicaid program is the source of continued benefits.

Mr. CARTER. Have you known of instances in which medicare—there are a couple on medicare. One of them is confined to a nursing home. The member who has been forced to pay an additional sum to keep his or her spouse in the nursing home.

Mr. THEVENOT. If I am not mistaken, the last Congress passed an amendment which changed the method by which eligibility is determined in the case of an individual whose spouse is in need of institutional care.

It is my understanding that previously there was considerable difficulty establishing eligibility where one spouse had resources that had to be counted.

Mr. CARTER. Well, they don't have very many resources. This has been found out.

Mr. THEVENOT. I believe the Congress has attempted to correct this hardship.

Mr. CARTER. Reports have indicated that contributions ranged from $50 to as high as $350, and seemed to be primarily based upon the relative's ability to contribute; that is it has very little ability to contribute, it would be $50; and more, up to $350.

Mr. GEOGHEGAN. Doctor, to the extent that practice does occur, it would be in violation of the program regulations.

Mr. CARTER. Yes, sir.

Of course, it would. That's what we are getting at.

Now, how widespread is this in nursing home facilities throughout our country? That's the purpose of this.

Mr. Geoghegan. I could not answer how widespread it is. I don't think it is widespread.

Mr. Carter. You don't think it is? Does it occur in New York City very often?

Mr. Geoghegan. I doubt very much if it would have occurred in New York on a frequent basis. There are very many things that have been wrong with the program in New York, but that's not one I have been informed about.

Mr. Carter. What about Illinois and Chicago?

Mr. Geoghegan. I can't speak to the practice in that city. It is not something that we have heard a great deal about, nor has it seemed to have attracted a great deal of attention in those States where intensive investigation of program abuse and nursing homes has been carried on.

Mr. Carter. We have had testimony this very day that vendors or entrepreneurs or brokers are now attempting to control nursing homes throughout the State of Illinois to medicaid—I mean—and so on. Have you had information to this effect?

Mr. Geoghegan. Were you speaking of the testimony this afternoon?

Mr. Carter. Yes, sir.

Mr. Geoghegan. I believe that dealt, sir, with the problem of factoring, did it not?

Mr. Carter. Yes. I recall factors, entrepreneurs and vendors. That's quite true.

I would like to ask you, is it widespread through that State?

Mr. Geoghegan. I can't answer the question, sir.

Mr. Carter. Is there a group attempting to control the whole action in this State?

Mr. Geoghegan. I have not heard that is true about institutional providers of long-term care.

Mr. Carter. Thank you very much for your testimony, gentlemen. I certainly hope it is not pervasive. We have a great deal of information to that effect.

Mr. Crowley. If I could respond to your earlier question, Dr. Carter, about what happens particularly in our facilities when a resident does deplete their medicare eligibility. If they can be transferred to medicaid, they are, if not, then there are private philanthropic dollars to assure that any resident of our facilities will not lose care because of their inability to pay.

Just one point on the question of payment that you raised to a facility by a patient who is already on medicaid.

The General Counsel for HEW recently ruled that it is permissible for a family to pay for those services which are not covered by the medicaid program. They cannot pay for those services for which the facility is being reimbursed under medicaid, but for services that would go beyond that that are not eligible for medicaid reimbursement.

Mr. Carter. What I was actually referring to was from personal knowledge and instances in which supplemental security income check had been taken from poor patients in nursing homes.

I regret to say this, gentlemen, but it is quite true. I had hoped that you all would certainly police your profession and see that these things don't happen.

Thank you, Mr. Chairman.

Mr. Rogers. Thank you.

Mr. Duncan?

Mr. Duncan. I have no questions. Thank you.

Mr. Rogers. Thank you so much. We are grateful for your presence here today.

The next witness will be Dr. Seymour Gers, chairman of the Committee on Medicaid, Area 2 Council, American Psychiatric Association, accompanied by Caesar A. Giolito, director of government relations.

Welcome to the committee.

STATEMENT OF SEYMOUR GERS, M.D., CHAIRMAN, COMMITTEE ON MEDICAID, AREA 2 COUNCIL, AMERICAN PSYCHIATRIC ASSOCIATION, ACCOMPANIED BY CAESAR A. GIOLITO, DIRECTOR, GOVERNMENT RELATIONS

Mr. Rogers. Your statement will be made a part of the record.

Dr. Gers. It is a privilege to be here on behalf of the American Psychiatric Association which represents 23,000 psychiatrists in the United States to discuss the medicare and medicaid antifraud and abuse amendments.

My name is Seymour Gers. I am a psychiatrist from New York City and the chairman of the Committee on Medicaid of the Area 2 Council, American Psychiatric Association. As chairman of this committee, I have had exposure to a wide variety of experiences in the medicaid program in New York.

Accompanying me is Mr. Caesar A. Giolito, director of government relations of the American Psychiatric Association.

It is our hope that the presentation of this short piece of testimony will mark the beginning of a productive dialog on psychiatric care in medicare and medicaid between your committee and this association. We are sympathetic with the objective to improve medicare and medicaid in quality of care and cost accountability.

In general, we support the intent of these amendments, and hope that their passage and implementation will bring about the desired results. However; we do have some serious concerns that this may not prove to be the case.

In examining these programs in relation to fraud and abuse, it is necessary that we first establish if any of these proposed amendments actually predispose to fraudulent or abusive manipulation.

In attempting to regulate, license, or force disclosure of the entrepreneurs of medicaid mill-type operations, we are in a sense legitimizing such operations, while discouraging the responsible individual practitioners from participating in these programs.

Present reimbursement rates and regulations actually reinforce the rewarding of mill-type operations and the exclusion of individual practitioners.

Incentives for quality care must be built into these programs, and inferior care must be discouraged. However, this does not seem to be the case in New York City.

Let's look at where current psychiatric medicaid expenditure is going: Of the $100 million for medicaid ambulatory psychiatric care, only about 10 percent went to individual practicing psychiatrists in 1976. More than 1,800 individual practitioners received a total of approximately $10 million, averaging $6,000 per practitioner per year.

By contrast, a handful of "shared facilities" billed more than $3 million for predominantly psychiatric ambulatory care. Even more striking is the fact that over $85 million was reimbursed to existing institutional facilities, clinics, and agencies, with levels of care which range from excellent to below minimal standards. Yet all these clinics were licensed and currently subject to audit and review.

Present licensing provisions do not necessarily assure the delivery of quality care superior to that delivered in medicaid mills. Another fact is that more than $240 million was billed to the New York State Department of Mental Hygiene in 1976 for a variety of services provided under the State umbrella. Yet, as in many other States, the State hospital system has been frequently criticized regarding the quality of care delivered.

In New York City the Health and Hospitals Corp., which provides almost all of the emergency and most of the acute psychiatric hospitalization, has also received its share of criticism for inefficient service delivery and a questionable quality of care. Right now in New York City, a medicaid patient attending a psychiatric ambulatory clinic of a municipal hospital would generate reimbursement of between $40 and $90 for a single visit. If that patient sought an individual practitioner in the same area, the maximum fee that could be charged by that psychiatrist would be between $28 and $30 under New York City reimbursement regulations.

We should also pay some attention to the reasons why patients seek out medicaid mills rather than the established hospital clinics which are already licensed, or individual practitioners. It would be simplistic to ascribe this to consumer ignorance and to dismiss complaints of overcrowding, impersonal treatment, lack of staff continuity, and budgetary and financial restraints of the institution which adversely affect patient treatment. Yet, all these clinics are currently licensed. Therefore, disclosure and registration provisions do not necessarily guarantee care delivery or discourage abusive practice.

We do have a problem with the definition of a "shared health facility" because it does not adequately differentiate those established practitioners who seek to assist new physicians in an area by making their offices available to them when they are not being used, thus sparing the high cost of opening an office in underserved areas. In these cases it would not seem to be unethical to share some office expense. We maintain that such practitioners should not be subject to compliance under these amendments, so as to encourage increased care delivery.

We must be sensitive to the possibility that many responsible and reputable practitioners, who are presently engaged in providing service through these programs, may become discouraged from further participation because of the increasingly negative image, excessive administrative constraints, and harassment imposed upon them. Dedicated practitioners with inner-city practices, providing essential service to the poor and medically indigent will be provoked to consider relocating their practices and to provide services outside these essential programs.

Another unfortunate occurrence is the innuendo of fraud and abuse that is often ascribed to practitioners simply because they have earned large reimbursement amounts from these programs, and whose names are published in newspapers without specific charges being made or verified. Large gross billings with high overhead and administrative costs, and a large number of personnel, do generate large volumes, but not necessarily high or exorbitant profits.

Although the American Psychiatric Association believes the PSRO amendments to be favorable and progressive in principle, there is some concern that premature involvement of PSRO's in policing, disclosure, and cost containment activities would nullify the desired intent of monitoring the quality of care. It has not been established that the cheapest care is the best quality care.

The American Psychiatric Association has been working diligently with its 70 district branches around the country to promote and improve its peer review activities. We believe that this function of our organization will provide one of the cornerstones for improved psychiatric service. We also wish to stress to the members of these committees the importance of maintaining confidentiality, especially in the treatment of the mentally ill. The enactment of laws to monitor and police fraud and abuse in the provision of service must in no way impinge on the confidentiality of the physician-patient relationship.

It is not clear that the savings to be generated by adoption of more antifraud and abuse legislation will significantly improve the imperfections in the existing medicare and medicaid programs, nor provide the level of cost containment we all desire.

Perhaps a system that rewards the efficient, responsible, nonabusive practitioners who provide high-quality professional service should be devised, rather than perpetuating one which rewards the superefficient skimpers and cost-cutters who abuse not only the patient but also his fellow professionals, and all of us as taxpayers.

I can't help but recall the one physician cited in a recent investigation of medicaid mills who essentially said to a patient, "There's nothing wrong with you," and did not prescribe treatment. He would probably not receive any reimbursement from current programs because he did not provide a treatable diagnosis nor order a battery of tests to bolster his clinical professional judgment.

The American Psychiatric Association wishes to improve the quality and delivery of care to the medically indigent and elderly population served by the medicare-medicaid programs, and will certainly cooperate in efforts to eliminate fraudulent and/or abusive practices which divert funds from this purpose.

However, legislation and regulations that merely foster the increasing use of organized settings for psychiatric care in order to provide closer surveillance and monitoring measures, actually discourages the participation by qualified individuals, and thus serves to deprive these populations of the benefits from high-quality care delivered by individual practitioners.

This does a disservice to the patients and destroys a pluralistic psychiatric profession. We believe there must be a better way to allow the population receiving public assistance to receive the quality benefits available in the private sector from individual psychiatric practitioners which was historically the goal of these programs.

The American Psychiatric Association stands ready to cooperate in providing input to devise or develop such programs.

Thank you.

Mr. ROGERS. Thank you very much, Doctor, for your statement.

Chairman Rostenkowski?

Mr. ROSTENKOWSKI. Thank you, Doctor; no questions.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I have one question. I notice that you state that the medicaid mills really charge more—charge $40 to $90 per visit, while your charges are $28 to $30 per visit; is that correct?

Dr. GERS. That is correct, in New York City. The regulations vary throughout the country; and even in New York State. There are separate regulations for each locality. In New York City, there is a limit that an individual practitioner can charge for a full, in this case, psychiatric visit. The limit is either $28 or $30.

Mr. CARTER. Why do you think that present legislation leads these people to such medicaid mills rather than to the sources of quality medical care?

Dr. GERS. The patients or the entrepreneurs?

Mr. CARTER. Sir?

Dr. GERS. The patients?

Mr. CARTER. Yes, sir.

Dr. GERS. I think the patients seek them out. They are voting with their feet. They are going there. They must be getting something. Perhaps it's the fact that they cater to them, they treat them nicely; they don't make them wait. They have the same staff there. The alternative, very often——

Mr. CARTER. Do they have board psychiatrists in their mills?

Dr. GERS. Unfortunately, I do not know. The material that I have gotten has been from the Department of Social Services when I had asked where is this money going? It does not seem to be going to the individual practitioners. In these shared facilities or mills, there are just a handful of them in New York City. I think there are maybe less than six. Yet they bill $3 millon; 1,800 psychiatrists only billed $9 million or $10 million.

Mr. CARTER. Thank you for your testimony.

Mr. ROGERS. I am not sure I understood why the difference. Is there any reason for there to be a difference from what the individual practitioner charges and the group practice?

Dr. GERS. These are regulations set by the medicaid administration as cost containment regulations. They want to keep costs down, so they put a limit. Of course, the clinics are not bound by these rules.

Mr. ROGERS. Thank you so much, Dr. Gers. Thank you, Mr. Giolito. I appreciate your being here.

Our last witness for today is Dr. Louis A. Finney, Chairman, Committee for the Neurosurgical Presence of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons.

I may say we appreciate your patience in bearing with us and being willing to appear as the last witness.

STATEMENT OF LOUIS A. FINNEY, M.D., CHAIRMAN, COMMITTEE FOR THE NEUROSURGICAL PRESENCE, AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS AND CONGRESS OF NEUROLOGICAL SURGEONS

Dr. FINNEY. I hope the last is not least.

Mr. ROGERS. The last will be first, as I recall.

Dr. FINNEY. I am Louis A. Finney, Chairman of the Washington Committee for Neurosurgery.

Thank you for giving me the opportunity to appear before your subcommittees today. I come as the official representative of the American Association of Neurological Surgeons with a membership of 1,916 and the Congress of Neurological Surgeons with a membership of 1,796. On behalf of this membership and at the direction of the two presidents, Drs. Lester Mount and Bruce Sorenson, I desire to comment on H.R. 3, the medicare-medicaid anti-fraud and abuse amendments.

We appear here today in support of the efforts of Congress to eliminate fraud and abuse in the medicare and medicaid program. We note that the bill under discussion calls for the Professional Standards Review Organizations to assume broad and potentially dangerous new powers and several new regulatory roles. Are these new functions duplicatory of existing Federal functions? We would also like to offer some suggestions for your consideration. Hopefully, these hearings will result in a revised version of H.R. 3, which will merit broad support.

We appreciate the concern of Congress in this legislation and concur in provider reimbursement solely for rendered services. Third parties should not reap excessive profits from the delivery of health care to beneficiaries and recipients of Government-sponsored health care programs. On the other hand, it must be presumed that other Federal business is transacted with private entities which utilize contingency financial arrangements and the services of factors. If these business arrangements are heinous, Congress should legislate an end of Federal dealings with any enterprises having contingency financial arrangements or which utilize the services of factors.

Mr. ROGERS. May I interrupt, or should we wait until there is some showing of evidence of fraud?

Dr. FINNEY. I merely make this statement: If fraud is present then I think it must be prosecuted in all locations. The presence of a factor for the collection of certain bills may not necessarily be fraudulent.

Mr. Rogers. That is what I am saying. Should we necessarily outlaw them all until there is some evidence of fraud in areas?

Dr. Finney. No, I don't think you can. We take the position that third parties should not excessively profit from the Government programs for health care.

Mr. Rogers. Thank you.

Dr. Finney. Nevertheless, we do support a currently worded section of H.R. 3, (a) which bar the use of factoring arrangements in the payment of medicare and medicaid moneys to physicians, (b) which require providers to disclose upon request specified ownership information and information pertaining to business transactions with related parties, (c) which allow Federal access to the books of providers of services under medicaid, and (d) which make clear that medicaid is the payor of last resort where other payors might have an obligation to cover the cost of services rendered to a medicaid claimant.

Our first area of concern is the interpretation of a shared health facility. What are medicaid mills? The present wording of H.R. 3 anticipates rules and regulations which would be categorized as shared health facilities all multiple physician medical buildings, medical groups, medical partnerships, and other sharing arrangements between financially independent physicians. Almost every physician could be affected by this bill. Do not allow H.R. 3 to specify doctors' offices for priority scrutiny by the PSRO. Do not leave the determination of a medicaid mill to the rulemakers. Congress must write this bill precisely so that those facilities thought to be unscrupulously preying on the poor, the near-poor, and the Government are targeted for investigation. At this very time the Medical Services Administration of the Federal Government is randomly reviewing records within the offices of physicians to verify that services billed have in fact been performed.

Our second concern is the assignment of a priority status for ambulatory health review by the PSRO. The primary review responsibility for PRSO's should continue to be institutional review. We have grave concern that the feasibility and cost-effectiveness of ambulatory care review do not justify priority review of shared health facilities at this time or in the foreseeable future. As the Medical Services Administration currently has the authority to review physician office records, is this section of the bill solely aimed at transferring this unwanted and onerous task to the physician population participating in PSRO?

Our third concern is the proposed upgrading of fraudulent activities under medicare and medicaid to the status of felonies. The spectre of criminalism may have unforseen effects on both the PSRO's and the government-supported health care programs. The fear of criminal prosecution added to existing civil liabilities will only serve to drive quality physicians away from the care of medicare beneficiaries and medicaid recipients.

Such a result is in conflict with the national goal of providing access to quality health care for all medicare beneficiaries and medicaid recipients. This problem might be alleviated by specifying several levels of penalties for abuses including disallowance with automatic appeal and review prior to formal criminal prosecution for misdemeanors of lesser magnitude than over fraud.

Our fourth concern is the granting of investigatory powers to the PSRO's. These organizations should not have search and destroy capabilities. We do not wish to see a law enacted which will create an atmosphere allowing the whip-sawing of a profession by various government entities. The practice of medicine is justifiably considered by the American public to be one of the most admirable of professions. If we may be pardoned for a historical correlation, please do not invoke an era of fear and witch hunting on the medical profession. Congress should consider designating by some index what wrongdoing is occurring before allowing expensive investigations of the sort advocated in this bill, or the randomized searches now taking place.

We now present a suggestion to which we hope you will give most sincere consideration. The neurosurgical community recognizes the inherent right of the government to require some knowledge of individuals or organizations with which they conduct financial transactions. Consultants for many Federal health care programs are chosen after careful review of their credentials. These choices are almost uniformly good.

Instead of discussing felonies and fines, Congress should consider an accreditation program for providers based upon ownership information and information pertaining to business transactions with related parties. PSRO would appear to have the statutory ability to compile the necessary information. All that is then required is to authorize PSRO to acknowledge the propriety of business relationships of providers for participation in medicare-medicaid. Under such an arrangement the PSRO's would require initial and periodic reports as well as interval reports when any significant change in the business aspect of a practice occurs.

It is our opinion that such an arrangement would be far more palatable to the overwhelming majority of sincere, dedicated, and honest physicians than the a posteriori penalty provisions of the current bill. Such an arrangement would preclude Federal reimbursement to any practitioner with fradulent business relationships. An ounce of prevention is worth a pound of cure.

Certainly Congress should refine the vague phrase "in accordance with procedure established by the Secretary" and define the role of the PSRO's in assisting Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating patterns of fraud or abuse. We are of the opinion that the PSRO's should have no investigatory powers and no powers to recommend indictment for criminal offenses. Such powers belong to the Department of Justice or the Inspector General of the Department of Health, Education, and Welfare.

We commend the recognition that health systems agencies and State health planning and development agencies need data input from the PSRO's. However, we also have concern over the disclosure of data generated by PSRO's and request a careful definition of the term "administrative proceeding" in the following wording of the bill "unless such disclosures are made in judicial, administrative, or other formal legal proceeding."

We also realize that all matters of health care are not and cannot be attended to in the same manner by all physicians. By giving PSRO's the right to determine exclusively what would have been best for the patient is giving them a right that few physicians and teachers can agree upon to this day.

In summary, the neurosurgical community does not recommend PSRO's performing ambulatory care review or assuming investigatory activities which may lead to criminal prosecution of physicians. We feel that Congress should very strictly limit their concern in this bill to those types of health service which notoriously prey on the poor and near poor.

We urge the Congress to mitigate most criminal activities by restricting participation in the medicare-medicaid programs to those providers acknowledged to have proper business relationships.

Again, than you very much for inviting me here today.

I am pleased to state that I have heard today that Federal attorneys for the northern district of Illinois and for the southern district of New York have also made the final suggestion to your committee. You have now heard it from a provider group as well as a legal group.

Again, thank you very much for inviting me here today.

Mr. Rogers. I think it is a good suggestion to look at the business relationships, but also I am not sure that that would necessarily do away with the need for a penalty. I would think you still might need penalties. I think your suggestion of moving into that area as you set forth on page 5 has merit. We will look into it.

Chairman Rostenkowski?

Mr. Rostenkowski. No questions. Thank you very much for joining us this afternoon.

Mr. Rogers. Thank you so much. Thank you for being here.

This concludes the joint hearings; and I want to say how much I appreciate the fine spirit of cooperation that has existed between my good friend, Dan Rostenkowski and his committee, and particularly their staff. It's been a most rewarding experience to have the joint committees meet in a most effective way, I think.

Mr. Rostenkowski. Well, thank you, Mr. Chairman. I certainly want to reflect the sentiments of the Health Subcommittee of the Committee on Ways and Means. We have enjoyed working with you on this particular piece of legislation. I am sure that this is the beginning of a longstanding relationship, I feel truly that we can prove by our cooperation and the cooperation of the department heads we listened to that we are on the threshold of putting together legislation that will benefit the entire country.

I want you to know that as subcommittee chairman, I enjoyed being with you this afternoon and look forward to a long working relationship.

Mr. Rogers. Thank you, Mr. Chairman.

[Whereupon, at 5:25 p.m., the hearing was adjourned.]

[The following was submitted for the record:]

UNITED STATES SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., March 17, 1977.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health,
Ways and Means Committee,
U.S. House of Representatives,
Washington, D. C.

DEAR MR. CHAIRMAN: We understand that you are currently considering action on H.R. 3/S. 143, the Anti-Fraud and Abuse Act of 1977. In this connection, we are pleased to submit for the record a summary of the evidence relating to the widespread practice of Medicaid kickbacks as collected by the Senate Committee on Aging over the past 7 years.

It is apparent to us that kickbacks continue to be a rampant business practice in Medicaid despite efforts by the Congress to curb this practice. Yet, only one case has been successfully prosecuted under the provisions of the 1972 Social Security Amendment (42 U.S. Code 1396 nn) which makes offering, soliciting, or receiving kickbacks a misdemeanor punishable by up to a year in jail and a $10,000 fine.

When we asked State and Federal prosecutors why so few kickback cases were prosecuted in view of the widespread nature of the problem, they told us that: (1) the cases are complicated, (2) they require a great deal of manpower and expense. This expense, they contend, is not justified to obtain misdemeanor convictions.

For these and other reasons, we strongly support the provisions of H.R. 3/S. 143 which would make Medicaid frauds, including the offering, solicitation, or receipt of kickbacks, felonies. We believe that it is time we crack down on the abhorrent practice of kickbacks which robs the taxpayer and contributes to ever escalating health costs.

With best wishes,
Sincerely,

FRANK CHURCH,
Chairman.
PETE V. DOMENICI,
Ranking Minority Member.

SUMMARY OF EVIDENCE COLLECTED BY THE SENATE COMMITTEE ON AGING RELATING TO KICKBACKS AMONG MEDICAID PROVIDERS

(By Senator Frank Church, Chairman Senate Committee on Aging and Pete V. Domenici, Ranking Minority Member, Mach 17, 1977)

Presented to: Honorable Paul Rogers, Chairman Subcommittee on Health, House Commerce Committee; Honorable John E. Moss, Chairman Subcommittee on Oversight, House Commerce Committee; Honorable Dan Rostenkowski, Chairman Subcommittee on Health, House Ways and Means Committee: Honorable Sam Gibbons, Chairman Oversight Subcommittee, House Ways and Means Committee; and Honorable Herman Talmadge, Chairman Subcommittee on Health, Senate Finance Committee

INTRODUCTION

In 1965, the Congress embarked on a bold new direction in enacting the Medicaid program, which consolidated medical assistance programs in an effort to bring a great quality of health care to the poor, the disadvantaged and the elderly. From 1966 through 1976, the program expanded ten fold, from $1.5 billion to $15.5 billion at the end of fiscal 1976.[1] An estimated 28 million Americans are eligible for the program.

Undoubtedly the program has been a major benefit to the needy who otherwise would be deprived of any medical services. However, in recent years, there has been increasing concern about the escalating cost of the program. More than half of the States have made major cutbacks in their Medicaid programs in the last two years.

To add to these significant worries there is new and mounting evidence that the program is not only inefficient but riddled with fraud and abuse.

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[1] Cost estimates for fiscal 1977 are about $18 billion.

In the past seven years the Senate Committee on Aging has conducted more than 50 hearings related to one or more aspects of the Medicaid program. A 12-volume report entitled, "Nursing Home Care in the United States: Failure in Public Policy" is under way. In February 1976, the Committee issued a report entitled; "Fraud and Abuse Among Clinical Laboratories", which charged that $1 out of every $5 spent for laboratory services under Medicare and Medicaid is fraudulent. In August of 1976, the Subcommittee released its much publicized report on "Medicaid Mills", entitled, "Fraud and Abuse Among Practitioners Participating in the Medicaid Program."

These reports have attempted to provide generic examples of the most frequent abuses of the system and to provide some recommendations for the benefit of legislative Committees.

This statement deals with what must be the most commonly occurring scheme to defraud the Medicaid program. The word "kickbacks" and the practice it connotes have been found to some degree in every aspect of the Medicaid system. Such rebates have the effect of increasing the cost of the Medicaid program. They undermine the quality of services which are offered since operators become more concerned with rebates than with care. As this paper indicates, the most frequent setting for such questionable transactions is the nursing home. However, increasing evidence points to hospitals, medical practitioners, clinical laboratories, and other suppliers.

This paper summarizes the evidence collected by the Senate Committee on Aging. It concludes that kickbacks are rampant and that a 1972 law enacted by the Congress to make them illegal is not being enforced. It is a plea for aggressive action to root out fraud and abuse, as promised by the new Carter Administration.

I. THE NUMBERS

In 1975 Americans spent an average of $547 each—or $2,188 per family—for health care. This is 3 times as much as was spent for health in 1965 ($39 billion) and 10 times the amount spent in 1960 ($12 billion). Measured in terms of gross national product, the cost of health has increased from 4.6 percent in 1950 to 8.3 percent today—fully one-twelvth of the GNP at the end of 1975.

The rapid growth in spending is associated with sharp increase in government participation. In 1965, public funds made up only 26 percent of all health expenditures; today public funds make up 42 percent of the total.

Medicaid is a Federal grant-in-aid program in which the Federal government provides 50 to 78 percent of the cost of providing health services to the aged, blind and disabled The amount of Federal match is determined by a State's per capita income. As a precondition of participating in the Medicaid program, the States must agree to provide at least the following services: hospital care, physicians' services, nursing home care, home health care, laboratory and x-ray services. Other services, such as eye care or dental care, may also be offered by the States and qualify for Federal matching.

Is fiscal year 1975, Medicaid paid $15.5 billion for health services. Some 37 percent of the money or over $5 billion went to pay for nursing home care, 31 percent ($4.9 billion) was paid to hospitals, physicians' services received 10 percent of all Medicaid funds or about $1.5 billion. The next largest category was prescription drugs at a little over $1 billion; dental services were funded at near $500 million.

The State of New York (23.3 percent), California (12.4 percent) and Illinois (6 percent) accounted for more than 40 percent of all Medicaid funds.

The U.S. average for per capita Medicaid payments was $66.60 in 1975. New York was the high with an average of $180.62 per inhabitant and Wyoming was the low with $16.14 per inhabitant.

In calendar year 1975, the 10 states receiving the most Medicaid money were as follows:

New York—$3.252.328.327
California—$1,483,990.363
Pennsylvania—$768,224,615
Illinois—$753.418.270
Michigan—$677,077,811
Massachusetts—$577,115,417
Texas—$519,912.780
Ohio—$413,276,480
Wisconsin—$402,039,501
New Jersey—$401,726,751

THE GROWTH OF NURSING HOMES

From 1960 to 1976, the number of older Americans in the United States increased 23 percent, from 17 million to more than 21 million. At the same time, the number of nursing homes increased 140 percent, the number of beds by 302 percent, and total expenditures for nursing home care by more than 2,000 percent. Details follow:

	1960	1976	Percent increase
Homes	9,582	23,000	140
Beds	331,000	1,327,358	302
Patients	290,000	1,000,000	245
Employees	100,000	650,000	550
Dollars (millions)	$500	$10,500	2,000

As noted above, 37 percent of all Medicaid monies or about $5.7 billion went toward the payment of nursing home care to some 15,569 nursing homes participating in the program. These facilities represent about 750,000 beds. Clearly, Medicaid pays the lion's share of the estimated $10.5 billion in yearly nursing home revenues.

II. THE LAW

In 1972, the Congress enacted an amendment to make the offer, receipt or solicitation of a kickback illegal—a misdemeanor punishable by a year in jail, a $10,000 fine, or both. At the same time, the Congress enacted an amendment (now section 162(c)(3)) which mandates that no deductions shall be allowed for any kickbacks, rebates or bribes paid under Medicare and Medicaid. Unfortunately, there has only been one case prosecuted under the kickback statute since its enactment in 1972 and the Internal Revenue Service has been anything but aggressive in its enforcement of the IRS Code provisions. The pertinent statutory language follows:

42 United States Code Section 1395

1395nn. Offenses and penalties

(a) Whoever—

(1) Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this subchapter,

(2) At any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) Having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclosure such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) Having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

"shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes items or services to an individual for which payment is or may be made under this subchapter and who solicits, offers or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or.

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services,

"shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or faiility in order that such institution of facility may qualify (either upon initial certification of upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in 1495x of this title), shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than 6 months or both.

Internal Revenue Code Section 162(c)(3)

(3) Kickbacks, rebates, and bribes under medicare and medicaid. No deduction shall be allowed under subsection (a) for any kickback, rebate or bribe made by any provider or services, supplier physician, or other person who furnishes items or services for which payment is or may be made under the Social Security Act, or in whole or in part out of Federal funds under a State plan approved under such Act, if such kickback, rebate, or bribe is made in connection with the furnishing of such items or services or the making or receipt of such payments. For purposes of this paragraph, a kickback includes a payment in consideration of the referral of a client, or customer.

III. THE EVIDENCE

The Senate Committee on Aging and particularly its Subcommittee on Long-Term Care, chaired by Senator Frank E. Moss, have documented in detail the extent of nursing home-pharmacy kickbacks. A report was released on this subject in January 1975 entitled, "Drugs in Nursing Homes: Misuse, High Costs and Kickbacks". Later hearings disclosed that kickbacks were also common practice between other vendors who served nursing homes. Kickbacks were also documented from clinical laboratories to medicaid mills and nursing homes.

In November 17, 1976 hearings, Senator Frank Church, Chairman of the Senate Committee on Aging, announced his intention to continue the efforts toward exposing and correcting fraud and abuse in the Medicare and Medicaid program which Senator Moss has initiated. In that hearing Senator Church and the Committee heard testimony that the practice of kickbacks was frequently the norm, the way business was done in the Medicaid program. Of serious concern was testimony implicating some welfare hospitals, which historically have not been identified with such practices.

CALIFORNIA

In 1968, the Senate Committee on Aging received a report by the Attorney General of the State of California which charged that it was common practice in the State for nursing home operators to require pharmacists to pay back a certain percentage of the price of nursing home prescription for the privilege of providing such services. The amount of kickback ranged from 25 to 40 percent of the total price of the prescription drugs delivered to the nursing homes.[3]

In 1970 and 1971, spokesmen for the American Pharmaceutical Association informed the Subcommittee and its staff that kickbacks were widespread and continuing particularly in California. A decision was made to look into the question in some detail.

In cooperation with the American Pharmaceutical Association. the Subcommittee fashioned a questionnaire which was sent to every pharmacist in the State of California and to 200 more throughout the Nation. In the questionnaire the word "kickback" was defined as: The practice whereby pharmacists are forced to pay a certain percentage of the price of nursing home prescription drugs, back to the nursing home operator for the privilege of providing those services.

The questionnaire was sent "blind", that is, no one needed to identify himself although many pharmacists took advantage of the opportunity to air their grievances. Some signed their names and some did not.

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[2] Evidence relates primarily to "ghetto" hospitals which specialize in welfare patients.

[3] Report by the Medi-Cal Program by the California Department of Justice Charles A. O'Brien, Chief Deputy Attorney General reprinted in hearings by the Committee on Aging, Cost and Delivery of Services to Older Americans, "Part 3, Los Angeles, California, October 16, 1968.

In all, the questionnaire was sent to 4,400 pharmacists; 40 percent, or 1,792, were returned to the Committee.[4]

Of the 1,792 responses received, 326 or 18 percent states that they had never attempted to serve a nursing home.

Another 18 percent, 328, indicated that they had attempted to deal with nursing homes but were not approached for a kickback and did not believe the practice was widespread.

Some 383 pharmacists or 21 percent indicated they had tried to serve a nursing home, had not been approached for a kickback but had a positive belief that they were widespread.

The remaining 755 or 42 percent of the pharmacists indicated that they served nursing homes and that they had been approached for a kickback. Of these 353 indicated that kickbacks were increasing, 51 indicated they were decreasing and 251 felt that they were about the same.

In other words, 63 percent of all pharmacists responding indicated an actual experience or a positive belief that kickbacks were widespread.

Pharmacists projected $10,363,000 in lost accounts from refusing to go along with kickbacks in 1971.

The average kickback was 25 percent, although some were larger. Postmarks identifying the State of Illinois among the 200 outside California, indicated generally higher kickbacks, but few as high as 50 percent.

But the pharmacists from all parts of the country did not limit their response to the questionnaire. Many provided the committee with written comments and with actual names of pharmacists and nursing home operators. In some cases, they made incredible admissions relating to their participation in forced profit sharing, allegedly to secure and maintain a nursing home account.

These admissions were made despite the fact that these practices are in violation of California law.

A few pharmacists accepted primary or joint responsibility for kickbacks. The following comments are typical: "The ethical pharmacists are not usually approached for a percentage kickback, most are prearranged by both sides." "In order to testify I would have to name the most important members of our association. Sorry I'm too small now." "Not being a member of our profession, I would not expect you to know how we operate. It is not the nursing home that instigates the kickback but the hungry-for-business members of our group. They are the ones who offer the nursing home the 'deal'."

Most of the replies the committee received are on the other side of the ledger. They charged that nursing home operators, driven by inadequate Medicaid reimbursement rates, were resorting to any and all methods to pick up a few extra dollars. For their part the pharmacists recognized little difference between discounts, collection fees, and rebates. A few were willing to accept as legitimate discounts of 10 percent, or less, given for quantity purchasing or to have nursing home accounts paid within 30 days. But these discounts were recognized only if voluntarily given and if such discounts could be given without inflating the costs of drugs to private paying patients to to Medicare and Medicaid. From the pharmacist's point of view, a voluntary discount rarelp happens. One pharmacis wrote: "I'm afraid to estify. My biggest account is a nursing home. If I lost this business, who will sustain me?"

Another said, "I own part of a nursing home and do not get any prescriptions from them, as I wouldn't kickback to them."

Still another commented: "In one pharmacy we served about 12 nursing homes. We were required to pay 25 percent to the operator of several of the homes and lost the business of three of them when we attempted to cut the kickback to 20 percent. The volume lost was in the vicinity of $5,000 a year."

One pharmacist noted: "Your effort is too late. Now many homes are owned by corporations that also own pharmacies and medical supply houses. No kickbacks as such are needed, they make it all in the pharmacy."

More typically, a pharmacist wrote:

"Gentlemen: This kickback in nursing homes is an absolutely rotten practice. And it is demanded by I would estimate at least 95% of homes in Southern California. Certainly, all large "chain" type operations demand it. These kickback demands are not only limited to drug services: all suppliers to nursing homes are required to participate—milk suppliers, laundry, food suppliers. Even the individual services of physical therapists fall under the demands of these ——. And that is the best description of most of these operators. I have attended their meetings, have known them socially, and have participated in their kickback demands. Their sole concern is for the "buck". Nothing else matters. And lowest on the list is the pathetic patient in these convalescent homes and hospitals. They are treated as a piece of living meat—a commodity."

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[4] See "Drugs in Nursing Homes: Misuse, High Costs and Kickbacks", Report by the Senate Committee on Aging, Subcommittee on Long-Term Care, January 1975.

Another stated:

"I am now required to give 30% to one home—have not agreed to it yet—feel I will lose the account if I refuse. Another home—Baptist Home—stated that their Pharmacy (an independent) always donated enough money to the home to cover the drugs purchased. Another home—Jewish home—stated that 15–20% was not enough—claimed they were getting more in kickbacks."

A Massachusetts man wrote:

"Why is it that a drug store say in Chelsea . . . is able to go all the way (20 miles) thru traffic, etc. and service a nursing home in Newton, Mass., West Roxbury, Mass., etc.?

"Why? Because he is a nice fellow . . . Hell no . . . kickbacks are so prevalent that you would be amazed at the discounts given in cash under the table . . . tax free . . .

"The only way I am able to beat competition on nursing home Rx service without giving a 20% kickback . . . is by 1) delivering papers to patients, 2) Show movies every week to patients, 3) inservice movies, 4) take urine samples to the hospital lab.

"In my estimate (based on factual information) approximately 99% give kickbacks."

An Illinois pharmacist wrote:

"It amazes me that Government on the one hand can shout to the roof tops about the high cost of drugs—and on the other hand—piddle and piddle around about discounts, kickbacks, rebates and such.

"Remember this—in any rebate situation, the rebate is added to the drug bill.

"It is the patient that pays——

"*Any cost involved in drug distribution system, any cost in accounting or any other cost in handling patients' medications—should be reflected or included in the daily room rate.

"*Any person giving or receiving any discount, kickback or rebate whatsoever should have his license revoked. This includes prepaid vacation trips and such."

A Florida letter read:

"Kickbacks" to nursing homes and extended care facilities have been prevalent in the Tampa bay area as long as I have been in the drug business; 1958.

"The practice increased sharply with the introduction of Medicare and Medicaid.

"I believe very strongly that Medicare placed a big club in the hands of nursing homes by allowing the nursing home to bill for pharmaceutical services and pharmaceutical consulting fees, and not allowing the pharmacy nor the pharmacist to effect their own billing; as do other professionals in the medical field. This practice has increased the cost of medications tremendously to nursing home clientel, no matter who pays the bill.

"I believe that practice of "kickback" to be present in 95% of homes in St. Petersburg, Florida."

Pharmacists wrote that kickbacks can be cash, i.e., 25 percent of total prescription charges or a flat $5,000 a year. They can be in form of long-term credit arrangements, or in some cases, unpaid bills to pharmacists. They can be in the form of rental or space in the nursing home—$1,000 a month for a closet, for example—or they can be in the form of a pharmacy bill to an individual patient in the nursing home where the home keeps 25 percent of the total bill as a "collection fee".

With some pharmacists the kickback is supplying the drugs, vitamins, and supplies at no charge, or merchandise offered to employees at no charge, or personal cosmetics and pharmacy needs of nursing home personnel delivered to the nursing home and charged to the home.

Other pharmacists pay the salary of certain nursing home employees who are ostensibly working for the pharmacy. Still others noted that outright gifts of large quantities of green stamps, new cars, color televisions, boats, desks and prepaid vacations to Hawaii or Europe are made. Some are required to advertise in the home's brochure at ten times normal prices.

Some nursing homes have opened their own pharmacy and offer shares in the corporation to other nursing homes if they agree to use this new pharmacy.

Examples of each of these abuses are provided below; they are quoted from replies the subcommittee received to its questionnaire.

CASH

"Another means of kickback is accomplished by just sending over to the owners (physician-owners love this one) 20–25 percent of the previous month's gross or a *present* fee in cold cash every month. Just put eight $50 bills or whatever in an envelope and hand deliver it to him or them."

CREDIT

"One such method to which I have been personally subjected in at least a couple of instances involved very strong pressure to grant excessive credit in amounts never allowed anyone else. In each case, the operator folded, leaving me stuck with an uncollectable bill of one to two thousand dollars each time.

"You might not consider this to be a "kickback". I do, for its origins, cause and effect were precisely the same as in the more formal instances you might have in mind."

RENTING SPACE

"Both places wanted me to rent a complete room in ECF plus supplying their own personal needs. This (at that time) was about $1,000-$1,200/month with an estimated percent to volume of about 20-25 percent. The pharmacy who had the 'contract' was renting a linen closet for $700/month for "storage". The home owner also wanted me to explore with him the setting up of a company to supply these homes (he had two and one in the planning stage) since if the supply costs were higher they would do better since they were on a cost plus percentage with the health agencies."

FURNISHING SUPPLIES

"I was requested to supply the nursing home with such things as mineral oil, aspirin, gauze pads, tape, etc. free of charge. These were things that the nursing home was being paid to supply in the daily rates set by the State.

"I was also requested to mail out prescriptions for drugs that were not used but instead I was asked to supply things that the nursing home was supposed to supply. These were to be charged to welfare but instead send to the patient a posey belt restraint."

HIRING EMPLOYEES OSTENSIBLY WORKING FOR THE PHARMACY

"Kickback demands are in various forms, not necessarily cash rebates. Two examples are: The supplying of certain drugs, vitamins, and supplies at NO CHARGE to the ECF. Paying the monthly salary of a full-time employee whose sole duty is to tell the pharmacy whether the patient is a MEDICAL, MEDICARE or private patient in the ECF, thus obstensibly working as an employee of the pharmacy, but in reality working for the ECF."

GIFTS OF TRADING STAMPS

"Kickbacks in this area are more subtle. For example, green stamps, advertising in facilities, promotional brochures at ten times the normal prices."

GIFTS OF COLOR TELEVISIONS AND BOATS

"I have no real proof of kickbacks on a specific situation as far as cash is concerned—however, I do know that on Christmas of one year, color TV's were delivered and paid for by one of the stores—also, the following year a boat was given—also, massive amounts of trading stamps are sent to the facility".

PREPAID VACATIONS

"In this area the 'kickback' is in the form of personal gratitude such as prepaid trips to Hawaii, Japan, a new desk, free use of a ski cabin, beach house, or other valuable usage."

ADVERTISING

"Because of my refusal to 'buy advertising space' in their monthly nursing home newsletter (a three-page affair) priced at $124 per month (my rebate computed at 10 percent of medical charges and 15 percent of private patient charges), I was dropped as the pharmacy to provide services. Whether I buy advertising space or slip them the money in cash under the table it is still graft and I certainly hope you are able to stem this horrible practice. I wrestled with my conscience as to whether I should suffer the $15,000 a year loss or whether I should "make up the difference" on charges for my new prescription for the private patients that would be reimbursed under extended Medicare funds. You would be absolutely amazed at the amount of Government money being sopped up by these "extra billings'."

AUTOMOBILE LEASING

"Another approach is that of auto leasing for the home's administrator. Maybe given him as a fringe benefit of his job by the owners. All kinds of things can be worked out by the leasing company whereby it is almost completely tax deductible. Most pharmacies have delivery cars, usually small and compact cars with low monthly leasing fees. Now, new Mark III leases for $225/month and a VW delivery car for $50 monthly. The leasing agency writes up any kind of lease it wishes; it can lease the Mark III to the rest home owners for $75 per month and charge the pharmacy $200 per month for the VW. Everybody is happy, IRS cares not because somebody is going to write-off the car as expense anyway, no cash has been lifted from the pharmacy so no books have to be juggled, and you get the business."

PURCHASING SHARES OF STOCK IN THE FACILITY

"Owners of nursing homes in our area have joined forces and opened pharmacies which only service nursing homes. They then offer interest in their pharmacy to other nursing home operators if they will use the pharmacy.

"One nursing home approached drugstores in our area as to the amount of kickback they would give to get the drug business. It was given to one drugstore. This went on for some time. Then the manager (a circuit judge) asked the drugstore supplying drugs to nursing home to buy stock in said nursing home for the business. This he wouldn't do and business was taken away and given to a drugstore that did. The amount of stock in corporation was $5,000."

Many pharmacists wrote of their serious concern about the conflict of interest presented where the ownership of the pharmacy and the nursing home overlap. One side of the argument is the ability to manipulate prescriptions to bill the Government and the other related to the ability to cover up mistakes:

Another reason I have never pursued nursing home accounts is because they are always having drug problems as most of them are operating without pharmaceutical assistance and often request drugs to cover up some they have borrowed from another patient. They have a number of reasons for requesting drugs early and an investigation will show that many laws are being violated daily and I don't intend to practice in this manner.

Several pharmacists believe that inadequate nursing home rates encourage nursing home operators to make a profit elsewhere. Many also felt that reimbursement formulas for welfare medications are too low, stating that the necessity to pay kickbacks leads pharmacists to many shortcuts. As an illustration, one pharmacist noted that a prescription might cost $4.50 plus a fee of $2.30. This was the most welfare would allow as a fee. Thus the total price of the prescription would be $6.80 and with a 25 percent kickback of $1.70 only 60 cents would be left over for profit, salary, rent, etc.

According, some of the pharmacists admitted:

(1) Billing welfare for non-existent prescriptions.

(2) Supplying outdated drugs or drugs of questionable value.

(3) Supplying stolen drugs which they have purchased or supplying discarded drugs (those belonging to dead or discharged patients).

(4) Supplying drug samples which they have received free of charge.

(5) Supplying generic drugs and charging the State for brand name drugs.

(6) Dispensing less than the prescribed amount and billing for the full amount.

(7) Raising the amount prescribed by the doctor (kiting) and billing for the same.

(8) Billing for refills not dispensed.

(9) Receiving payment from a patient and submitting invoice for payment.

(10) Using a particular line of drugs because the manufacturer has a price list where every item is listed at a higher price than is actually charged. By using such products the pharmacist can charge the State more and make a higher profit.

The practices above are highly questionable and in most cases clearly illegal. There are many reasons for the prevalence of these practices but the primary cause is the reimbursement system for nursing home drugs.

How does this system work? Obviously, there are many variations among the 50 states but in general the practice works as follows. The pharmacist presents a bill (often unitemized) for prescriptions to the nursing home. The nursing home then bills each individual patient, collecting from those who pay for their own drugs and sending the balance to the State welfare department or to Medicare for payment. Neither the welfare department nor the Medicare intermediaries examine the billings very carefully. Most are paid automatically. Upon receiving payment from these third party payers, the nursing home then reimburse the pharmacist (often keeping a prearranged percentage for handling", etc.)

This policy of allowing the nursing home to act as the "middle man" between the pharmacy (which supplies the drugs) and the source of payment (private patient, Medicare or Medicaid) creates an inviting atmosphere for abuse. The shortcomings of this questionable policy are obvious:

(1) Medicare, Medicaid, and the private patient have no idea what they are paying for. The bill does not come from the pharmacist, but from the nursing home, and it is often unitemized. Close scrutiny of a bill is extremely difficult, if not possible.

(2) "Cozy" relationships between pharmacies and nursing homes are encouraged whereby both parties can benefit at the expense of the private patient and the public. With the taxpayers $2 out of every $3 that goes into nursing homes, the implications of a nursing home owning its own pharmacy are all the more serious.

(3) In the end, pharmacies and nursing homes find it easy to cover up mistakes and increase their profits.

In order to obtain the nursing home operator's view of this question, Senator Moss directed that a questionnaire be sent to every administrator/owner in the State of California. About 2,050 questionnaires were sent out, 619 or 30 percent were returned.

Of the 619 returns, only 20 nursing home operators indicated having an interest in a pharmacy; 60 percent (373) indicated that their nursing homes were served by more than one pharmacy; 78 percent (484) nursing home providers stated that they had never offered or accepted a kickback; 67 percent (415) indicated they did not believe kickbacks wre widespread.

For the most part, nursing home owners were much less free with their additional written comments. The comments that were received related to the definition of the word "kickback" and to the inadequate nursing home reimbursement rates.

Nursing home operators went to great pains to emphasize a difference between unearned "kickbacks" or other considerations and earned service discounts. They pointed out that in many cases, nursing homes bill all the patients in their homes and that they collect the money from their individual private paying patients. This saves the pharmacist the cost of billing and collecting from nursing home patients individually. It also allows the pharmacist to receive a lump sum payment which is paid by the nursing home on behalf of its patients.

If the pharmacy were troubled to collect from individual patients, presumably it would have to wait longer for its payment. In the case of Medicare and Medicaid, pharmacies often have to wait for months for final payment. The nursing homes feel they create a cash flow for the pharmacist and that they guarantee payment from individual private paying patients. For this service and because of the large quantities of drugs purchased, many nursing home operators believe that they are entitled to a cut or discount.

The following comments are typical: "Everyone gets their cost except the nursing homes so they must accept discounts from the pharmacy". "Kickbacks are wrong in any field, however, I do not feel a discount for buying volume merchandise and providing bookkeeping services for billing are wrong. Discounts are part of the American scene." "The common misconception is that a pharmacist should receive retail prices for, let's say, 400 prescriptions delivered to the nursing home and which the nursing home collects for the pharmacy, guaranteeing payment. An arrangement involving a fee for nursing home services should be recognized as legitimate. Some pharmacists want full retail for a 'wholesale' account and don't care who pays. Nursing homes in most cases bargain for better prices and pass at least part of the savings on in terms of reduced costs, or as discounts taken, etc., to their patients private and Medicare."

Clearly, the results of the two questionnaires indicate two differing points of view. On the one hand, pharmacists indicate they are forced to pay a kickback as a precondition of obtaining a nursing home account; on the other hand, nursing homes claim they are legitimate discounts justified by their quantity buying or because of "billing services" performed for the pharmacist. The line between "kickbacks" and discounts is perhaps difficult to draw. However, there are several factors which should be considered.

Is the arrangement between the parties disclosed?

Is the "discount" voluntarily given or is it mandatory?

Is the "discount" a prerequisite of doing business with the nursing home?

Is the amount (or percentage) of the discount nominal or excessive?

The Committee Staff next decided to discuss the alleged problems directly with the industry. Officers and members of the American Nursing Home Association met with Senator Moss and the subcommittee staff and pledged their best efforts toward preventing kickbacks. They offered to define the relationship between the nursing home and the pharmacist and to distinguish kickbacks from earned discounts. The Association in fact appointed a blue ribbon panel, promising the subcommittee a full report addressed to these objectives. Their efforts resulted in a 2½ page list of "suggested principles" in which the term "kickback" is not even mentioned. The essence of this document is one line: "The financial arrangement between the pharmacist and the nursing home should be fully disclosed."

By contrast, spokesmen for the National Council on Health Care Services (NCHCS) gave the problem far greater attention in 1973. A press release from NCHCS says in part, "Nursing home 'kickbacks or rebates' pose a serious threat in the relationship with the pharmacy profession and in the optimum delivery of health care." The executive vice president of NCHCS offered some definitions:

"Rebate—Where a home takes back a dollar percentage of all drugs delivered. Certainly illegal for Medicare drugs when only reasonable costs are paid for, a bit unsavory when applied to Medicaid drugs, and hardly conscionable when an unreported profit is made on private patient drugs.

"Kickback—Similar to rebate, only more so, usually with an 'under the table' connotation.

"Discount—If unearned, then in the same category as rebates and kickbacks.

"Earned discount—When a nursing home is rendering a service for the pharmacist which he would normally be required to perform, such as billing and collections, where the nursing home, like Bankamericard and similar bank credit cards, guarantees payments to the pharmacist for all drugs ordered; and where the pharmacist gives a nursing home a service or volume-discount, as most suppliers do for other goods and services, the National Council of Health Care Services believes that a discount can and should be offered by the pharmacist in return for services rendered.

"On the other hand, if a nursing home demands a reduction in charges from the pharmacist without offering any compensatory advantages to the pharmacist, an unwarranted situation is occurring and should not be countenanced."

H.R. 1: KICKBACKS MADE ILLEGAL

As noted above, there was no specific prohibition against kickbacks until November of 1972 when Public Law 92 603, section 242, became law (otherwise known as 42 U.S. Code section 1395nn). The law made kickbacks a misdemeanor punishable by a year in jail, a $10,000 fine, or both.

KICKBACKS CONTINUE

In early 1974, the Committee sent its same questionnaire to 100 pharmacists who had responded in 1972. The overwhelming response from those who had previously stated kickbacks were widespread was that the practice was continuing unabated.

In order to further document this practice the Committee asked for testimony from the California Pharmaceutical Association. Mr. Charles D. Brown, President of that association, appeared before the Committee on November 13, 1975. Mr. Brown was reminded of his 1972 response to the Committee's questionnaire in which he stated that pharmaceutical rebates were running rampant in California. Senator Charles Percy asked him whether this were still the case. Mr. Brown responded:

"Yes, it is; especially in the metropolitan areas."[5]

He estimated that 40 percent of all pharmacists participated in rebate schemes, again noting concentration in the urban areas. He said that he personally had lost 5 accounts because he refused to go along with kickback requests. The dollar volume of those lost accounts he estimated was $200,000.

He described several new kickback techniques. The first involved the home's charging the pharmacy a fee, purportedly to store drugs in the facility (the only storage involved may be the prescription bottles for the patients). He said that many operators were demanding service from pharmacies which offered unit dose concept in terms of reducing medication errors but he objected to operators insisting pharmacists install such systems in order to obtain the nursing home's account. This is particularly true, said Brown, when the unit dose systems turned out to be owned by a medical supply firm in turn owned by a major nursing home chain (which was the parent company of the home he had asked to serve.

He added tht the new regulations which require nursing homes to employ consultant pharmacists has been exploited by nursing home owners to the point of being a kind of kickback:

"There is nothing in the State law which requires a facility to reimburse the pharmacist for those services. Therefore, pharmacists are using this as a tool to obtain accounts and nursing facilities are saying, "If you want to retain the acount, you will not ask for this amount, but you will perform the service."[6]

Brown stated that private paying patients and Medicare were absorbing the average 25 percent kickback that is required to obtain a nursing home account. "(T)he unethical provider makes money and the ethical provider loses business." He added that the intervening Federal statute, 42 U.S.C. 1396, enacted by the Congress in 1972, has had "no effect" on the kickback problem. He stated that if a few providers were prosecuted, "the practice would diminish considerably." "We feel that mandatory penalties along with compete restitution should be required", he said.[7]

In early 1976, the Committee received a number of serious allegations from a former nursing home operator licensed in the State of California. He asked that his name be withheld, fearing possible reprisals and the safety of his family. He alleges "pyramiding" of nursing home ownership. He said he had partial control of 4 nursing homes, yet never invested any of his personal capital. He alleges declaring only 30 percent of his annual salary for income tax purposes. He states he had the free use of leased cars and credit cards. He admits paying physicians and hospitals $50 for each patient referral.

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[5] Medicare and Medicaid Frauds, Hearings by the Subcommittee on Long-Term Care, Senate Committee on Aging, Washington, D.C. November 13, 1976, p. 265.

[6] Ibid. p. 263.

[7] Ibid. P. 264.

When asked about the current levels of rebates or kickbacks in California, the former nursing home administrator and owners said the following were average rates paid to nursing homes:

1. Pharmacies pay 25 percent.
2. Physical and Occupational therapists 50 to 60 percent.
3. Food supplies, he said were competitive except that some owners were supplied food for their personal use.
4. Laundry—he alleges that no rebates are paid as the industry is controlled by organized crime.
5. Undertakers pay 20 percent.
6. Cemetary lot sales, including tombstones, may bring operators a 20 percent rebate.
7. Contractors pay 10 percent of the gross construction price of a new nursing home.

State and Federal authorities are investigating these allegations, which are considered highly credible. Our Committee has hard evidence to substantiate the 25 percent pharmaceutical rebate.

The Committee staff has also documented numerous examples of kickbacks between clinical laboratories and Medicaid practitioners in California. California and Federal authorities have been apprised of these fundings. California Governor Edmund G. Brown, Jr. and Secretary of Health and Welfare Mario Obledo recently announced a major initiative to crack down on fraud and abuse in the State of California.[8]

FLORIDA

Following publication of the report, "Drugs in Nursing Homes: Misuse, High Costs and Kickbacks," published by the Subcommittee on Long-Term Care, the Secretary of the Florida Department of Health appointed a Committee "to investigate and determine if the general allegations made in the 'Moss Report' about drug kickbacks from pharmacists to nursing homes is a practice in Florida, and if so, to what extent."

Under the direction of Jack H. Jones, Coordinator of Pharmaceutical Services, the Committee sent a questionnaire to every pharmacist in the State of Florida. Some 30 percent of the 863 questionnaires were returned.

Twenty-five percent of the responding pharmacists said they had been approached for a kickback (as compared to 42 percent who told the Senate they were approached in California).[9]

Some 90 percent of the pharmacists in Florida indicated their belief that kickbacks were widespread between pharmacists and nursing homes (as compared with 63 percent of California pharmacists who thought so).

About 50 percent of Florida pharmacists said that it was necessary to give a kickback in order to obtain a nursing home account and about this same number said they had lost accounts because of their refusal to go along with requested rebates.

Only one quarter of the Florida pharmacists reported that kickbacks were increasing; about 60 percent said the level was about the same and the remainder thought that kickbacks were on the decline.

In a similar survey of Florida nursing home operators, over 90 percent reported they had neither been approached for a kickback nor had solicited such payments. As noted, in the Senate survey, 78 percent of all nursing home operators in California answered similarly.

The Committee concluded its report as follows:

One general conclusion which encompasses the entire scope of charge to the Committee was reached by unanimous consent of the members. That conclusion is that a definite problem exists in the State of Florida with respect to rebate and kickback arrangements between vendors and nursing homes and that some remedial action, whether legislative, administrative or both is necessary." [10]

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[8] Medicare and Medicaid Frauds, Hearings by the Senate Committee on Aging, Part 9, March 9, 1977.

[9] Final report of the Department of Health and Rehabilitative Services Nursing Home Pharmaceutical Services Study Committee and cover letter to Senator Frank E. Moss conveyed to the Senate Committee on Aging on February 16, 1976.

[10] Ibid p. 44.

More specific conclusions offered by the Florida Committee include:

"Present laws and administrative rules are either not stringent enough or are not being enforced to a degree that serves as a deterrent to nursing homes and vendors against engaging in unethical financial arrangements."

"Excessive discounts, rebates, and kickback situations exist in Florida to the financial detriment of the nursing home patient and the taxpayer."

"Both the vendor and the nursing home must share the blame equally when a financial arrangement contrary to public policy is entered into."

"It is the best interests of all concerned—the patient, the nursing home, the vendor, the relatives or guardians of the patient, the taxpayer, and the government—to provide strong sanctions against unethical financial arrangement. A chain is only as strong as its weakest link, and it is the opinion of the Committee that no nursing home or vendor whose primary concern is excessive profits will be able to concentrate in patient services to the degree that will guarantee an acceptable level of quality."

The Committee added that both pharmacists and nursing home operators must share the blame for kickbacks. They declared:

"The only discount a nursing home is entitled to is that discount in return for reciprocal services provided to the vendor."

In short, the Florida Committee stated that "it does not believe a party to such contracts should be able to receive 'something for nothing.'" Any inequity in arrangements between vendors and nursing homes should be investigated through a cross audit, that is an audit of the books and financial records of both parties. It also recommended that "all contracts between vendors and nursing home be on file with the Department and open to public inspection and that all financial arrangements including discounts be described in detail.[11]

WISCONSIN

In July of 1975, an investigation by the Milwaukee Sentinel revealed a pattern of illegal kickbacks between pharmacies and nursing homes in that State. Specifically, the Sentinel reported:

One pharmacist had been paying a nursing home $3,000 to $4,000 a year for the privilege of selling drugs to the home's Medicaid and private patients. The exact amount, he said, was based on a bed count formula.

Another pharmacist estimated that he had paid more than $25,000 to a nursing home in kickbacks from the sale of drugs to its Medicaid and private patients.

A Catholic nursing home dropped the pharmacist servicing its patients after he refused to kickback a portion of his profit on each Medicaid prescription.[12]

Partly as a result of these disclosures, a Federal grand jury investigation was opened under the direction of William Mulligan, United States Attorney, Eastern District of Wisconsin. Aiding in the investigation is Lt. Governor Martin J. Schreiber, who has an active interest in nursing home problems for several years.

According to the Sentinel's survey, nursing home-pharmacy kickbacks are a significant problem in Wisconsin. W. Allen Daniel, Executive Director of the Wisconsin Pharmaceutical Association acknowledged that kickback schemes exist. Speaking for his Association, he said: "We are adamantly opposed and condemn both the nursing home administrator who would demand such improper considerations from the pharmacist and the pharmacist who would accept the contract." According to Sentinel sources, the average kickback in Wisconsin ranges from "token amounts up to 30 percent of sales."[13]

ILLINOIS

In 1971, Senator Moss received a letter from an Illinois certified public accountant which triggered hearings by the Subcommittee on Long-Term Care in that State. The CPA implored the Senate to do something about the kickback problem. He said that the following was true with respect to a chain of nursing homes with whose books he was familiar:

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[11] Ibid, quotations in this paragraph found on page 45 and 46 of the report.

[12] "Druggist Kickbacks Bared," *Milwaukee Sentinel,* July 7, 1975, p. A1 by Gene Cunningham and Dan Patrinos.

[13] Ibid, p. A1.

1. The pharmacies which supply these nursing homes have agreed to a "kickback" to the home which averages out between 25-30 percent on all prescription drugs delivered to the home.

2. A 50 percent across the board "kickback" is given by the pharmacies on all welfare prescription (prescriptions paid for in part by a third party)."

The existence of some kickbacks was quickly confirmed by a questionnaire to 100 Illinois pharmacists and by an HEW Audit Agency report. The audit agency noted that the Illinois reimbursement formula for drugs could lead to high profits, which could be used to pay kickbacks. Illinois paid pharmacists their average wholesale cost plus a profit of 30 percent, plus a constant factor of $1.35 per prescription.

One result from this letter was the full-scale study of practices in the State of California reported above. The same questionnaire was sent to 100 pharmacists in the State of Illinois. Some 58 percent of those who replied indicated they had been approached for a kickback or believed that they were widespread.

The U.S. General Accounting Office also found evidence of nursing home pharmacy kickbacks in its April 23, 1975 audit of the State of Illinois, entitled, "Improvements Needed in the Medicaid Program Management Including Investigations of Suspected Fraud and Abuse," prepared at the request of the Senate Finance Committee. GAO, in part, verified findings by the Bureau of Health Insurance. Specifically, there were no prescriptions for 17 of 363 claims which a pharmacy had submitted to Medicaid for payment. Moreover, a pharmacy paid $4,500 a month to a management company for services performed at four nursing homes. The management company was owned by the spouses of the owners of the nursing homes. BHI officials were told that the services performed were reviews of patients' charts to determine the accuracy of medications ordered or dispensed.

However," reports GAO, "BHI Region V officials believe that the payment may have been in the form of a kickback for the privilege of obtaining the nursing homes' drug business."

On February 5, 1976, United States Attorney Sam Skinner, Northern District of Illinois, returned an indictment against eight defendants and owners of the above nursing homes. The indictment charged a conspiracy to defraud the government under the terms of Title 42, United States Code, Section 1396. (These were the first indictments under the 1972 law enacted by the Congress to try to stem kickbacks). The indictment charged that the Ideal Drug Company paid a kickback equal to $5.00 per month for each patient at the Evergreen Nursing Home whose drugs could be and were paid for by Medicaid.

Allegedly, Ideal Drug obtained the money from its cash receipts without recording that amount as part of income to or as a disbursement of the company. It was further agreed that the kickbacks from Ideal Drug were to be paid to Multicare Management Company for distribution by Multicare Management Company to various individuals who, either personally or through their spouse, held an ownership interest in Evergreen Gardens Nursing Home. The indictments also specify that it was part of the conspiracy that the true nature of the kickbacks paid through Multicare be concealed by Ideal Drug from the government by labeling the kickbacks as fees for consulting services although no consulting services were provided by Multicare Management to Ideal Drug. It was also part of the conspiracy that the kickbacks not appear on the books of the Evengreen Nursing Home.

As a final postscript the indictment charges that defendants made an entry in the books of the Evergreen Gardens Nursing Home indicating that Multicare owned Evergreen $4,500, after the defendants became aware of an investigation by the Bureau of Health Insurance.

Testifying before the Senate Committee on Aging on November 17, 1976, Mr. Skinner reported that his office had obtained a conviction against the named defendants who among themselves controlled almost 25 percent of the nursing homes in the State of Illinois. In addition to incarceration for about 90 days each the operators were fined some $900,000 by the Court. Mr. Skinner questioned the fiscal integrity of the Medicaid program, calling it the "biggest ripoff in history."[14] Although he obtained the first convictions under the 1972 law,

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[14] Medicareand Medicaid Frauds, Hearing by the Senate Committee on Aging, Part 7, November 17, 1976 unpublished.

Skinner argued that the penalties for offering, receiving or soliciting kickbacks in the Medicare or Medicaid programs be strengthened to felonies. His recommendation, also concurred in by Assistant United States Attorney, George Wilson, Southern District of New York, has been integrated into H.R. 3, the Anti-Fraud and Abuse bill, introduced by Congressmen Dan Rostenkowski and Paul Rogers in the House of Representatives and by Senator Herman Talmadge in the Senate.

CLINICAL LABORATORY KICKBACKS

In September of 1976, the Committee staff documented one example of kickbacks between clinical laboratories and a physician who had a large volume Medicaid business. Knowing that the practice was clearly illegal, Committee investigators set out to find an answer to an essential question: how common was the practice? An extensive discussion among the staff of the Committee on Aging led to the conclusion that the best way to test the extent of such practices would be to simulate the actions that would be taken by an independent physician beginning a practice specializing in public aid (welfare) patients. To this purpose, it was decided that a storefront clinic would be opened in an appropriate area. Only from the perspective of the practitioner, at street level, could the Committee gain information on the mechanics of these highly questionable operations. And only through understanding the mechanics of the operation could effective corrective legislation be proposed.

A decision was made to go ahead with this plan in conjunction with the Better Government Association (BGA) of Chicago, Illinois, a non-profit, nonpartisan civic organization which has cooperated with the Committee on Aging for more than 6 years in a number of areas of investigation. Subsequently, due to considerations of time and money, the BGA assumed primary responsibility for setting up and operating the storefront clinic with Committee staff present only as observers. Two Illinois physicians cooperated with investigators to the extent of allowing their names to be used.

A small storefront was rented at 1520 West Morse in the Rogers Park area of Chicago. This neighborhood has the highest proportion of aged in any area in Chicago . . . and possibly one of the highest in the Nation. A sign announcing the opening of the clinic was placed in the window. A number was listed with the statement: Professional Inquiries Invited. Mr. Douglas Longhini, a BGA investigator, posed as a business representative of the two doctors. Working with the BGA personnel was Producer Barry Lando and other individuals from the CBS television program "60 Minutes," who modified the storefront clinic. They installed special lighting and a one-way mirror, hoping to film those who entered the clinic offering kickbacks to the disguised BGA investigators.

Over the next 3 weeks, business representatives from more than 12 laboratories doing more than 65 percent of the Medicaid business in the State of Illinois visited the storefront clinic. All but two offered some form of inducement or kickback. The offers ranged from an "educational program" for physicians in billing procedures, to maximize return from public aid, to cash rebates of more than 50 percent of gross payments received from Illinois Department of Public Aid.

In addition to Mr. Longhini, Mrs. Geralyn Delaney, A BGA secretary, was present during each of the interviews which took place, recording the conversations that took place in shorthand.[15] At times, BGA Investigators Patrick Riordan was present. Mr. Recktenwald and David Holton, temporary investigators for the Senate Committee on Aging, were present on several occasions, posing as maintenance men. As an example of what transpired in these visits the following exchange between Mr. William Footlick, owner of Division Medical Laboratory, said to be the largest lab in terms of public aid business in the State of Illinois, and Douglas Longhini is reprinted below as taken from Mrs. Delaney's sworn statement:

(Mr. Longhini asked what arrangements were made.)

Mr. FOOTLICK. "A percentage of the volume of business in dealing with public aid."

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[15] Particular care was taken to make sure that no Federal or State laws were broken in this effort. Illinois has a statute which prohibits electronic recording of conversations unless all parties consent to it. Accordingly, the best alternative available was stenographic recording.

Mr. Longhini asked Mr. Footlick how many square feet the lab would need to draw the blood.

Mr. FOOTLICK. "A blood drawer, chair, and cabinet."

Mr. Longhini stated the clinic's rent is $450 a month. If the clinic's business is brisk in the beginning the clinic could get that $450 back in rent.

Mr. FOOTLICK. "Oh Sure, $5,000 to $6,000 a month."

Mr. Longhini asked whether the clinic would get $5,000 to $6,000 a month for rent.

Mr. FOOTLICK. "Sure * * * volume of people."

Mr. Longhini asked if the clinic would sign a lease.

Mr. FOOTLICK. "Sure * * * wouldn't be able to refer to rent until we look at volume. We would have to renegotiate the lease."

Mr. Riordan asked whether the clinic's rent would change four times a year.

Mr. FOOTLICK. "I don't think it would be fair to do once or twice and get good idea of volume."

Mr. Riordan asked whether Mr. Footlick's firm provides a technician to draw the blood.

Mr. FOOTLICK. "Depends on volume."

Mr. Longhini asked Mr. Footlick if the clinic gets a rebate off the volume.

Mr. FOOTLICK. "A rose, is a rose. I look at it as a rental."

Mr. Longhini asked whether the clinic was safe from the FBI.

Mr. FOOTLICK. "FBI frowns upon an incentive for the doctor to draw in a lot of * * * on kickback system * * * I justify it would cost more to bring these patients to the lab than if I were to do the work here."

All in all, the offers received by BGA personnel ranged from a small discount offered to private patients to the full package offered by Mr. C.'s firm, including: 20 to 30 percent of gross billings which would be paid in the form of rent (said to be as much as $5,000 to $6,000 a month) Plus salary for a clinical secretary or a nurse, Plus equipment and supplies, Plus x-ray and technician's services, Plus electrical plumbing services for the clinic.

Typical of the kickback offers was that of Mr. Nemie LaPena, representative of a Northside clinical laboratory. In the first 6 months of fiscal year 1976, his firm was paid $550,802.64 for laboratory services by the Illinois Department of Public Aid (Medicaid), making them among the highest paid labs in Illinois for that period.

In a meeting with BGA Investigators Douglas Longhini and Geralyn Delaney on December 23, Mr. LaPena said:

"You'll make lots of money, I guarantee that * * * you'll get a rebate of 45 percent of your gross public aid billings. I'll deliver a check to you every Tuesday; and if your billings go over $1,000 per week, then the percentage goes up to 50 percent."

During this conversation Subcommittee investigators were also present and overhead the offer.

INTERVIEWS WITH PHYSICIANS

From information gathered at the storefront, a profile was constructed of each laboratory. Billings presented to the State for medical testing on public aid patients were pulled and examined. The physicians using the services of labs identified were selected for interview. On January 7, 1976, interviews were made.

Four teams of investigators comprised of one BGA and one Senate staff member, conducted more than 24 interviews on that day. Physicians were asked: (1) Whether they did business with a particular lab as indicated by bills paid by the Illinois Department of Public Aid; (2) whether they had an arrangement with that lab; (3) the details of any such arrangement; and (4) to examine particular bills submitted on their behalf by medical testing laboratories and paid by the Illinois Department of Public Aid.

In the great majority of cases, physicians confirmed the existence of "arrangements." They provided specifics concerning the amount of rebates and the method of payment. The primary exceptions to the above were cases the physician was an employee of another physician, or a third party, or otherwise on salary from the medical clinic.

In one such example of the latter, the investigators interviewed Dr. Jose Jaime Hilao, of the Robert Taylor Medical Center, Chicago, Illinois. Dr. Hilao indicated that he was on salary and that he knew nothing of any rebate arrangements. He referred the Committee staff to Mr. Robert C. Parro, president, Robert Taylor Medical Center. Dr. Hilao volunteered that Mr. Parro also owned the Professional Medical Center in Chicago.

Mr. Parro told Val J. Halamandaris, associate counsel, Senate Committee on Aging, and BGA investigator James Huenink that he (actually the two clinics) received some $300,000 the previous year in Medicaid funds from the Department of Public Aid. He added that one of his clinics had been using the services of the North Side Medical Laboratory in Chicago and that the Park-Dewatt Laboratory provided service to the second of his centers. Now both medical centers are using the Parke-Dewatt Laboratory.

Mr. Parro stated that his present arrangement amounted to 50 percent of the amount his clinic charged Medicaid lab services on behalf of Medicaid beneficiaries.

He added that he was troubled by this arrangement in that some might think it illegal. He described it as a gray area and stated that the law should be clarified. He added that his decision to give all of his business to this particular laboratory was not motivated by the desire to make greater profit. He volunteered that the North Side Medical Laboratory, which he had been using in one of his clinics, had offered him a kickback of 55 percent of total public aid billings which he turned down because he was dissatisfied with the services of this particular laboratory.

Halamandaris and Huenink also interviewed Mr. Roy Oliver, administrator, 47th Street Medical Center in Chicago. Mr. Oliver indicated that this medical clinic received some $250,000 from the Department of Public Aid last year. The clinical lab services were provided by a laboratory which provided a rebate of 30 percent of total volume (approximately $900 a month). The debate was received, disguised as a rental fee for a 5- by 7-foot room in the clinic. In addition, the lab paid $325 a month (some $160 each) to two clinic employees.

In the other situation most frequently found, the physician is the owner of the clinic. Dr. W. M. William Winstanley, King Drive Medical Center, told investigators Halamandaris and Huenink that he received some $100,000 from Medicaid for his medical center last year. He paid a rent of $1,050 a month. He receives rental of $1,000 a month from a pharmacy subleasing space in this building; a dentist pays him about $800 a month and an optician about $400 per month. He sends his lab business to the United Medical Laboratory. They pay him a constant $950 a month which he views as a rental fee for a 7- by 10-foot room in his clinic. In addition, he is paid $130 per month for an employee to draw blood and perform related services in this room. (These specifics should not be interpreted as making any judgments as to the quality of medical services offered by Dr. Winstanley. It is assumed he is providing needed and valuable service to his community.)

Other arrangements which other physicians admitted included: Acceptance of salary for staff supplies and equipment, the use of double pricelists, rental arrangements based on volume, and discounts for private paying patients. Discounts for private paying patients enable a physician to have tests such as a urinalysis done for him free or at a sizable discount. The doctor can then turn around and bill private patients $3 to $5. With respect to rental agreements based on volume. Dr. Julio Lara-Valle told investigators that the third largest laboratory in terms of public aid business (D. J. Medical Laboratory), paid him $1,000 a month for the use of a closet-sized room in a suite that cost him $300 a month to rent.

Senators Frank E. Moss and Pete V. Domenici interviewed Dr. Lara-Valle. He told them that the D. J. Medical Laboratory was now closed down and that its operator (Mr. Espino) "has flown the coop." Dr. Lara-Valle confirmed that he now has the identical "rental" arrangement with another laboratory.

The Committee report on this investigation concluded that a few laboratories control all the Medicaid business in Illinois and four other States: New York, California, New Jersey, and Pennsylvania. Kickbacks are widespread among such labs.

It added: "In fact, it appears that it may be necessary to give a kickback in order to secure the business of physicians or clinics who speciailze in the treatment of welfare patients."

The average kickback to physicians or medical center owners in Illinois was 30 percent of the monthly total the labor received for performing tests for Medicaid patients. Kickbacks took several forms including cash, furnishing supplies, business machines, care or other gratuities as well as paying part of a physician's payroll expenses. Most commonly it involved the supposed rental of a small space in a medical clinic.

The report concludes that it is apparent that the law passed by the Congress in 1972 prohibiting kickbacks and mandating a $10,000 fine and a year in jail upon conviction is not being enforced.

To date, U.S. Attorney Sam Skinner has obtained indictments against six of the laboratories who offered investigators rebates at the Morse Avenue storefront clinic.

UTAH

The Bureau of Health Insurance documented and the United States Attorney in Salt Lake City, Utah is currently prosecuting two nursing home owners whose alleged kickback scheme appears to be identical with that used by the Illinois operators (above). The nursing home owners appear to have funneled kickbacks to them from a pharmacy through a medical supply firm and a consulting firm, both owned by the nursing home owners. The allegation is that what are disguised as payments from the pharmacy to the supply and consulting firm are really kickbacks to the nursing home operators since said consulting and supply firms provided few if any services for the pharmacy.

NEW YORK

The Subcommittee on Long-Term Care conducted a major investigation of nursing homes in New York State in January of 1975. Over 60 subpoenas were issued to nursing home operators, vendors, insurance companies, and banks. Among the recurrent problems which the Subcommittee encountered was evidence of kickbacks not only between nursing homes and pharmacists, but between nursing homes and other vendors, as well (for example, those supplying linen, produce, and milk).

After its February 17, 1975 hearing the Subcommittee decided to turn these books and records, together with analyses by GAO auditors, to Charles J. Hynes, Special Prosecutor for Nursing Homes, State of New York, appointed by Governor Hugh Carey. Since that time, Mr. Hynes has obtained over 100 indictments and more than 27 convictions.

Testifying at the Committee's November 17, 1976 hearings, Mr. Hynes described an elaborate 18-month investigation into nursing home kickbacks. A cooperating nursing home owner wore a microphone and recoring device while negotiating contracts for his nursing home with over 30 suppliers in New York City. The recording equipment captured elaborate kickback offers from cash to prepaid vacation trips. Mr. Hynes indicated that others wore recording equipment to help his office and that more than 50 conservations were recorded.

On the basis of these recordings, Mr. Hynes had announced 26 indictments on November 16, and 16 more on March 11, 1977. He stated he expected many more indictments to follow. When asked how prevalent the kickback problem was in New York, he indicated that it was widespread and that perhaps half of the 125 nursing homes in New York City were involved in kickback schemes.

"Our indication is that the same kinds of abuses are found in all provider services in Medicaid," said Mr. Hynes. "Kickbacks were paid to nursing homes by linen, laundry, milk, produce vendors as well as by contract cleaning firms and medical supply houses."[16]

In answer to a specific question from Senator Church, Mr. Hynes said he had direct evidence of kickbacks to hospitals. Some of the suppliers who admitted kickbacks to nursing homes had also admitted similar arrangements with welfare hospitals, he responded.

In the course of its investigation of "medicaid mills" and related abuses in New York, the Committee staff documented kickbacks were a common practice between clinical laboratories and medicaid mills in New York. Both Assistant U. S. Attorney George Wilson, Southern District of New York, and New York County District Attorney Robert Morgenthau have obtained several indictments against laboratories in the past six months.

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[16] New York Times, November 16, 1976, p. A.1.

SUMMARY AND CONCLUSIONS

After 7 years of investigation and more than 50 hearings, the Senate Committee on Aging has received significant and convincing evidence that kickbacks are widespread in the Medicaid business. As one provider wrote, "Kickbacks are a way of life in Medicaid; there is a little larceny in us all."

After the Committee's in-depth investigaitons into the States of New York, California, Wisconsin, Florida, Illinois and other states, there can no longer be any doubt about this pervasive practice which picks the taxpayer's pocket.

The evidence is overwhelming that many pharmacists are required to pay kickbacks to nursing home operators as a precondition of obtaining a nursing home's business. Pharmacists also must pay rebates to practitioners or other owners of Medicaid mills, the small share health care facilities which checker the ghettos of our major cities. Moreover, there is increasing evidence that these same payments are being made to some hospitals which specialize in welfare patients.

It is evident that kickbacks are frequently required from clinical laboratories if they hope to obtain the business of both medicaid mills and nursing homes. Committee investigators are convinced that laboratories are barred from obtaining a Medicaid account unless they pay kickbacks. This fact in part accounts for the consolidation of laboratory business. In New York 16 laboratories controlled 70 percent of the State's Medicaid business. In New Jersey, a dozen labs controlled more than 60 percent of the funds. In Illinois, 12 laboratories controlled 65 percent of the State's Medicaid business.

Based on the intensive investigation conducted by Charles J. Hynes, Special Prosecutor for Nursing Homes in New York State, as well as testimony received by the Committee, it is apparent that kickbacks to nursing homes from vendors and suppliers such as purveyors of meat, linen and laundry services, produce, groceries, medical supplies, and contract cleaning services also make under the table payments to nursing homes with regularity. While the evidence is still unfolding in New York, it is evident that these same vendors and suppliers also pay kickbacks to some hospitals.

What is just as certain as the conclusive evidence that kickbacks are widespread in Medicaid is the fact that few cases of this nature are ever prosecuted. Only one case has ever resulted in a successful conviction specifically under the 1972 law Congress enacted. Medicare officials disclosed that only 18 kickback cases were referred for prosecution in the Medicare program since 1969. Medicaid officials had no accurate count to offer but indicated the number of kickback cases reported to HEW by the States would be negligible. In the 12 months, July 1974 through June 1975, only one case of kickbacks among Medicaid providers had been reported to HEW by the States.

When asked why so few prosecutions resulted, United States Attorneys and States' Attorneys told the Committee staff that kickbacks were among the most complicated and difficult to prove. Moreover, the penalty provided under the 1972 law is a misdemeanor. Prosecutors indicated they found it hard to justify the expenditure of man hours on misdemeanor violations.

RECOMMENDATIONS

1. HR 3 should be enacted. Of particular importance is the provision which make offering, soliciting, or receiving kickbacks a felony (instead of the present misdemeanor) in both Medicare and Madicaid.
2. The Department of Justice should intensify its efforts to identify Medicare and Medicaid fraud and to recover Federal funds inappropriately paid out under these programs.
3. The Internal Revenue Service should begin a systematic analysis of the tax returns of high volume Medicare and Medicaid providers.
4. The Congress should provide 100 percent Federal funding to the States for a three-year period to help them hire investigators and auditors. After the three-year period, the States should be allowed to keep 75 percent, or perhaps even 100 percent, of any funds they recover which have been fraudulently paid to providers.
5. All Federal and State authorities should make an aggressive effort to eliminate kickbacks which apparently are the normal way of doing business in the Medicaid program.

U.S. Senate,
Committee on Government Operations,
Senate Permanent Subcommittee on Investigations,
Washington, D.C., March 7, 1977

Hon. Dan Rostenkowski,
Chairman, Subcommittee on Health,
Ways and Means Committee.

Hon. Paul G. Rogers,
Chairman, Subcommittee on Health,
Interstate and Foreign Commerce Committee,
U. S. House of Representatives,
Washington, D. C.

Dear Chairman Rostenkowski and Rogers: I appreciate your invitation to testify before your hearings on H.R. 3, and I am sorry that my schedule on March 3 was such that I could not present my statement before your committees. Likewise today, I will be chairing hearings in the Senate.

I am sorry that I will not be able to give this testimony in person, but I hope you will include my remarks in the record of your hearing. As you know, I am co-sponsor of legislation introduced by Senator Herman Talmadge who has led the Senate efforts to address the problems of fraud and abuse in our health programs. I intend to ask Senator Talmadge and the Committee on Finance to consider the same proposals I am including in my remarks to you.

You are to be commended for your work. But we all must realize that we are only now initiating the first legislative steps toward controlling the ex-excesses of certain individuals and institutions. I am looking forward to working with you in the future, and I am especially grateful for the spirit of cooperation that exists within the Congress over this most important issue.

Sincerely,

Sam Nunn
Vice Chairman.

Statement of Sam Nunn, U.S. Senator in Congress from the State of Georgia, and Vice Chairman of the Permanent Subcommittee on Investigation

I am pleased to share with you experiences of the Senate Permanent Subcommittee on Investigations. I would like to commend you for your efforts to address the problems of fraud and abuse in our health programs. I also would like to express our gratitude for the technical assistance and cooperation your able staff has extended from time to time to the staff members of our Subcommittee.

For the past few years we have read newspaper reports, seen television accounts, participated in hearings and heard our own staffs tell us of examples of fraud and abuse in our health programs. These have not been reports of simply isolated examples. They have been indications of a dangerous condition in the industry upon which we rely to keep us healthy and save our lives.

The now constant disclosures of fraud and abuse do not involve, for the most part, people from other walks of life who see an opportunity to make a fast buck in health care. More often than not, the persons identified as shady characters have been in the health care system all along. Whether we are referring to fradulent kickbacks to physicians for directing their business to certain labs or the overbilling of Medicaid mills, many of the individuals involved are not new to the health care system.

While this kind of fraud, identified by the Senate Special Committee on Aging, is obviously wrong, there is yet another type of a more quiet and perhaps more expensive wrong-doing, that is little more than a sleight of hand.

For example, the increase in the number of malpractice suits has resulted in honest physicians ordering excessive numbers of tests on patients, as prospective protection against the posibility of such suits. This is understandable but it is as harmful as the patient who files a frivolous suit. There are the hospitals tht keep patients in beds over weekends or admit patients on Friday, with no work done on them until Monday morning. This is wasteful.

There are numerous business practices, taken for granted in the health industry, that we can reasonably regard as wrong or abusive because they unnecessarily contribute to the mind-boggling increases in our overall health care bill.

None of us really knows how pervasive is fraud against our health and welfare programs. Nor do we really know the extent of the abuse. What I know, as vice chairman of an investigating committee, is that I can ask my staff to look at almost any program and they will return with fraud or—and this should be more important to all of us—an attitude on the part of private citizens, be they patients or providers, tht government program dollars are there for the taking.

Furthermore, in each case we have studied, we have found that many government admininstrators seem not to be concerned that the program funds they are spending are the hard-earned tax dollars of American citizens. There is an almost cavalier attitude on the part of some of our government program administrators at levels where the real decisions are made.

Recently in a hearing before our Subcommittee, three employees from the federal Medicaid Management Information System Program testified to how their superior wrongly approved the spending of millions of dollars. The Department of Health, Education, and Welfare employees said that on one occasion this superior told them, "Look, don't show me what the regulations tell me I can't do. Show me ways to circumvent the regulations."

In another case involving a Subcommittee inquiry into abuse of mentally disturbed children in a federally funded institution, a government witness acknowledged that he knew of injury and even torture of children, but that he did nothing about it. He was asked if it would have been worthwhile to take some action against the institution if even one child could have been spared. In reply he coldly and simply said that one institution was not enough for him to worry about. He said this agency had to take 'a broader view."

In December, a physician came before the Subcommittee and invoked his rights against self-incrimination. He was the recipient of $1.2 million in federal funds to develop a health maintenance organization in New York City. We wanted to know if he intended to set up the same kind of HMO in New York as he had in California, where he is held in some disrepute. The HEW official who authorized the $1.2 million grant to the physician and the New York group he represented had conducted no background check on the physician and he told the Subcommittee that it was not his responsibility to do so.

The HEW official who allegedly directed his staff to circumvent the regulations, the agency head who had to take a broader view and ignore the injury of children and the man who agreed to a grant of $1.2 million without checking a physician's background are still in their jobs. They were not reprimanded. Their decisions were not reviewed until our Subcommittee got involved.

But it gets worse. In the fall, we held hearings on the Medicaid Management Information System (MMIS) program and heard testimony from a businessman who said he paid a program official money for writing MMIS contract proposals. In addition, the contractor provided the HEW official with a leased luxury car. This HEW official declined to appear before the Subcommittee and did not comply with our subpoena for his records. In spite of all this, HEW officials found they could only suspend him under Civil Service regulations and he subsequently resigned. The Department of Justice is now conducting an inquiry into this matter.

Congressmen, how can we make demands for honesty and integrity in the private sector when we neither apply any standards nor impose similar demands upon government program administrators and officials. Indeed, it is the people in government who know better than we know the real problems in the programs. Their failure to make decisions that beg to be made and their sometimes wanton disregard of their responsibilities to spend program funds in an appropriate manner creates an environment for fraud and abuse.

As we in the House and the Senate strengthen our fraud and abuse laws, I hope we will begin to consider a standard and a means to enforce accountability for the decisions made by government officials.

But there is an even more important step Congress should take. We in Congress should step back from what we have done over the past decade and re-evaluate each and every program. We should determine whether programs are in conflict; if there are duplications; overlap; and realistic goals. But most importantly, we should develop an overall health policy and carefully implement programs to assure the policy goals are achieved.

Above all, we should slow down. In December hearings before the Subcommittee, I asked Dr. Keith Weikel, the Federal Medicaid Commissioner, if we should try to manage the programs we already have before we pass national health insurance or any other new program. He said:

"My personal opinion is that we need a great pause. We need not to leap, but to crawl to national health insurance. We need process of incrementalism rather than a gigantic step, if you will. There are a lot of these problems that we can't solve. But we need some time to work with the system we have."

The Permanent Subcommittee on Investigations has conducted a number of reviews in the health and welfare area, but of specific concern to this hearing would be findings from a more than two year study of Prepaid Health Plans (PHP) in California and the federal Health Maintenance Organization Program.

In 1972, the State of California, in an effort to control its rapidly rising Medicaid program costs, began contracting with non-profit prepaid health plans to provide health care services to program beneficiaries the plans would enroll.

I have included in my extended remarks problems peculiar to prepaid health plans, which I hope you will consider in writing a final version of H.R. 3. But the Subcommittee's review of that program developed issues beyond the narrow confines of prepaid health plans.

For example, we found in that inquiry, as well as another investigation, actions by state employees which would have been violations of federal conflict of interest laws had these actions been done by employees of the Department of Health, Education, and Welfare. As a result of my testimony, I hope you will consider adding to H.R. 3 a provision that would extend to state and county Medicaid officials and employees, federal conflict of interest statutes since these individuals have fiduciary responsibilities on the federal government's behalf of relating to the expenditure of the federal share of Medicaid program funds.

In the first case, a Deputy Health Secretary for California quit state government and set up a management, consulting and computer service company to assist Prepaid Health Plan applicants to get contracts. Once with contracts he provided them with computer and management services. He charged the plans a percentage of their gross receipts from the state Medicaid program. Such percentage charges should be outlawed.

He employed former state workers who put the PHP computerized eligibility system together and they helped the plans develop their own eligibility systems.

In another case involving our inquiry into the (MMIS) program, a contractor developing the system in West Virginia told the Subcommittee that the Medical Director for the state Medicaid program bought stock in his company. In addition, the state official, who had oversight responsibility over the MMIS development in West Virginia, became a consultant to the contractor in the State of Arizona, where the company also was developing an MMIS system.

In both cases, state officials knew of the conflict of interest. West Virginia officials concurred in it and the California Attorney General reviewed the matter of the entrepreneurial former official and found that he had violated no law.

During the Prepaid Health Plan Investigation, the Subcommittee also found that State Health Department investigators were directed not to write reports or were given new assignments after they turned up siuations in 1972 and 1973 that confirmed the corruption of the program. For example one investigator testified that he was told not to write a report on the involvement of organized crime figures in one plan. Another investigator said that he was sent off to investigate the alleged theft of 13 steaks from a mental hospital freezer after he reported widespread abuses in certain prepaid health plans.

Where there are state Medicaid investigators, there must be an independent third party to either receive their reports, but more importantly, to direct their activities. They should not be, as they are in California, under the direction of Medicaid program officials who may cover up investigative findings, which could damage the program's image. Furthermore, I suggest that all work in progress reports on audits and investigations as well as final reports be submitted to the HEW Inspector General.

Finally, our inquiry into Prepaid Health Plans showed that most of the more than 50 contractors were non-profit corporations and that almost all of these corporations contracted for services they needed with partnership or companies owned or controlled by the directors of the non-profit corporations.

We found that though federal and state regulations required that subcontracts be reviewed and approved by state and HEW regional office officials, they were not. I would like to place into the record of this hearing a General Accounting Office Staff Study entitled "Relationships Between Nonprofit Prepaid Health Plans With California Medicaid Contracts And For Profit Entities Affiliated With Them."

The corporate inter-relationships between primary government contractors and provider institutions is a matter of grave concern to us. Through these inter-relationships, the contractor can show little or no profit. Indeed, he can show extraordinary costs, which may be generated by second and third tier subcontractors in which corporate directors and officers or others may have substantial interests and from which profits can be diverted.

The Federal Government has naively presumed for too long that non-profit corporations assure us of altruistic and benefiient management of program and grant funds and that somehow, for-profit corporations are selfish and sinful.

A witness appearing before a Subcommittee hearing in December who is the president of one of the plans referred to his own corporate structure as a "pretzel palace"—a complicated corporate maze which he said was "unnecessary." The General Accounting Office said an audit of one of these plans would cost more than $500,000 in government employee time.

Gentlemen, let me assure you that these corporate inter-relationships are not peculiar to prepaid health plans. They can be found in homemaker and home-health agencies and in certain institutional providers. We also have found them in computer service companies.

They are legal corporate designs to deceive us, and to take advantage of our tax law loopholes. Their effect is to increase program costs.

A related issue is already contained in H.R. 3's Section 3. The Section provides that upon the request of the HEW Secretary, or the General Accounting Office, providers other than individual physicians, receiving payment under either Medicare or Medicaid disclose specified ownership information pertaining to business transactions with related parties.

I would recommend that this disclosure requirement be mandatory for ownership interest of five percent or more. This information could be used in a mechanized or computerized information system and could serve as an extraordinary device for enforcement.

I would like to include in the record of your hearings at this time a summary of problems and proposed solutions arising from our hearings into Prepaid Health Plans and the federal health maintenance organization program.

BACKGROUND

The 1976 Amendments to the Health Maintenance Organization Act (P.L. 94-460) included several amendments to the Social Security Act. These amendments addressed a number of problems which had been identified in organizations serving the aged and the poor under federally-supported health care programs. A new section was added to the Medicaid law which for the first time defined HMOs for purposes of receiving federal matching funds and prohibited (with certain exceptions) payments to other organizations providing services on a prepaid risk basis. Under the new law, the definition of an HMO for both Medicare and Medicaid is made to conform to the definition of an HMO under the Public Health Service Act with certain exceptions based on the unique characteristics of each program.

Under the provisions of P.L. 94-460, HMO's under Medicare and Medicaid are required, with certain exceptions, to provide services in the manner specified under Section 1301 (b) of the PHS Act (which specifies per capita payments, basic and supplemental services, staffing, and accessibility of services). For Medicare, "basic services" are those provided under Parts A and B of the program, while for Medicaid the term refers to the mandatory list of services (except for SNF and EPSDT services). For Medicare, the law exempts organizations from employing a community rating system and specifies that payments and premiums shall be in accordance with Title XVII requirements. Both programs, with certain exceptions, are required to be organized and operated in the manner prescribed by Section 1301(c) of the HMO Act (which specifies fiscal operation, enrollment, and organization). Medicare HMOs are bound by the reinsurance and open enrollment provisions of Title XVII.

P.L. 94–460 requires HMOs under Medicare to have half of its enrolled members under age 65 while for Medicaid half of the enrollees may not be covered under either Medicare or Medicaid. If organizations show that they are making substantial progress toward meeting the enrollment provisions, application of these requirements may be delayed for three years for both programs. Medicare further requires, with certain exceptions, that HMOs have an annual open enrollment period. Medicaid, on the other hand, is governed by the modified open enrollment requirements of the PHS Act.

P.L. 94–460 requires the Secretary to administer determinations for both programs as to whether an organization is an HMO through the Assistant Secretary for Health's office in an integrated fashion with the administration of the enforcement provisions of the PHS Act. Administration of the remainder of the HMO provisions under Medicare must be done through the Commissioner of Social Security. Under Medicaid, states are permitted to make provisional determinations as to whether an organization is a qualified HMO if no determination has been made by the Secretary within 90 days of application.

The amendments to Medicaid prohibit matching to organizations providing services on a prepaid risk basis unless the organization is a qualified HMO or unless it is one of the organizations specified in law [community health centers, migrant health centers, non-profit primary health centers in rural areas under the Appalachian Regional Development Act of 1976, or organizations which have had long-standing contractual arrangements to provide Medicaid services (not including inpatient hospital services) on a prepaid risk basis.

The 1976 Amendments thus addressed a number of the problems which had been identified by the Subcommittee in certain newly established and loosely organized organizations serving predominantly Medicaid patients. These additional amendments, however, strengthen the requirements where necessary and provide for a closer coordination with the provisions of governing participation of HMOs under the Medicare program.

Recent congressional action began to bring about some degree of coordination to HMO law and regulations under Medicare and Medicaid. However, much more needs to be done in the interest of eliminating conflicts between not only these two programs, but also of the Civil Service Commission Regulations applying to the Federal Employees Health Insurance programs and the Public Health Service's HMO program.

The Congress should be quite concerned with acts and practices surrounding the development of health maintenance organizations. Not only does the HMO Act encourage their development, but also the economic realities of the health industry may encourage their more rapid development in the coming years. Furthermore, the financing, organization and delivery of health care services through an HMO is a most appropriate alternative to our present and dominant fee-for-service system. But we must ensure that some HMOs do not continue to be havens for abuse.

SUBCOMMITTEE INQUIRY

In the fall of 1974, Senator Henry M. Jackson, Chairman of the Permanent Subcommittee on Investigations, authorized the staff to conduct a preliminary inquiry into the Prepaid Health Plans (PHP's) receiving Medicaid funds in California.

Not only was the Subcommittee concerned with allegations of fraud and patient abuse, but also, a study of the program afforded us the opportunity to obtain a prospective view of what we might encounter under a national health insurance program that involves Health Maintenance Organizations (HMO's).

To understand the issue, some background is in order. In 1971, many states began to feel a severe financial strain caused by the unending escalation of Medicaid program costs during a period of economic recession. California, in response to this situation, turned to Prepaid Health Plans, which offered the prospect of controlling program costs and providing quality health care at the same time.

Under the fee-for-service reimbursement system, there is an incentive to treat patients. The more treatment, the greater the income. Under the HMO or PHP system, administered in good conscience, persons who need treatment get it, but the incentive is to keep patients healthy so they will not need more expensive care. The HMO or PHP receives a fixed monthly amount for each patient enrolled in the plan. This forms an income ceiling under which the plan administrators agree through contract to provide for the health care needs of the people they serve.

In short, the plan is at financial risk. If the cost of providing health care services to enrollees is more than the amount they have agreed under contract to receive, they must still provide the services. Threfore, the incentive is to practice preventive medicine, to keep enrollees in good health and avoid high cost services.

The California Prepaid Health Plan program won the attention of state officials elsewhere, not only because it offered the hope of reducing costs, but also because it was a step toward maintaining quality in Medicaid programs. Moreover, the fee-for-service system had in some cases raised questions about patient treatment, stemming from over-utilization of services for patients not actually in need of those services.

The examples cited in advocacy of the PHP program were the Kaiser Foundation Health Plan, the Group Health Association of Washington, D. C. and the Group Health Cooperative of Puget Sound.

California was not the only government interested in HMOs. Congress authorized in 1973 an expenditure of more than $325 million to test health maintenance organizations nationwide. Congress thought at the time that if HMOs could be gradually developed across the country, they would be viable entities by the time a national health insurance program was passed. These HMOs could be easily phased into such a program.

I believe we should encourage the development of health maintenance organizations, but we must do so only after we recognize the extraordinary potential for fraud and abuse inherent in this system. On the same hand, let us not forget that those who would abuse and defraud a health maintenance organization come from the predominant fee-for-service sector, where we already know there are great problems.

I believe a review of conditions in the California PHPs tells us a great deal about the medical marketplace from which government purchases health care services for program beneficiaries.

1. Reimbursement Safeguards

A. Calculating a Fair Payment Rate

Our investigation demonstrated that California negotiated grossly excessive HMO payment rates. In some cases, the resulting windfall profits were a consequence of the HMO's success in limiting Medicaid enrollments to people in good health, or of HMO practices that deprived enrollees of needed care. In many cases, windfall HMO profits were simply a case of the state not having a business-like approach to the calculation of fair rates. State auditors found profits, stated as a percentage of gross Medicaid receipts, ranged from six percent to 33 percent. Subcommittee staff found returns on invested capital as high as 3000 percent.

I propose that Medicaid payments to HMOs be calculated in the same way as under Medicare. Under this approach, HMOs whose operating experience and scale of operation is not sufficient to provide a satisfactory base for a sound actuarial rate determination would be reimbursed by Medicaid on a cost-only basis. HMOs that satisfy requirements relating to enrollment, scope of services and fiscal integrity, and accountability could elect to be paid on an incentive basis. Under this reimbursement method, an HMO would share with Medicaid any savings it achieves by providing all needed covered services for less than Medicaid would have had to pay had the enrollees been treated elsewhere in the community.

B. Integrity of Reimbursement System

The Medicare law requires HMOs to submit independently certified financial statements that have been prepared in accordance with the HEW Secretary's regulations. To date, the Secretary has not issued regulations that establish a uniform system of accounts and reports for HMOs. Therefore, HMOs can select from the various accounting options available to them so as to maximize their reimbursement rates.

I propose that the Secretary be directed to develop and require the use of uniform charts of accounts and reports for HMOs under Medicare and Medicaid so that inflation of the reimbursement ratio cannot be accomplished through accounting techniques. Futhermore, HEW should define each account so that financial information can be consistent among the HMOs.

C. Management Information

Because HMOs are not required to account for individual services in order to be reimbursed, many do not have information necessary for good management and financial planning or for the identification of gaps and failures in their delivery system.

An intended by-product of the proposed accounting and reporting system is that it would generate the data that both the HMO management and purchasers of the HMO's care need in order to appraise the HMO operations and costs.

D. "Prudent-Buyer" Requirement

Our investigation has shown that HMOs have paid exorbitant prices for goods and services they have purchased. In some cases, this has been done because the HMO operators had a financial interest in the organization selling the items. However, excessive payments could also be made in exchange for kickbacks or simply out of lack of competence.

I do not believe that government programs should be required to reimburse HMOs for costs that exceed the amounts that a reasonably prudent businessman would have paid. I propose to make the so-called "prudent buyer" principle that has been adopted by Medicare explicit in the Medicare and Medicaid law. The proposed new provision would state that the programs would not be responsible for reimbursing HMO costs that are in excess of the amount that a reasonably prudent businessman would have paid.

E. Avoidance of Large Overpayments

Investigations have shown that HMOs have been able to collect large overpayments from the Medicaid program that have been difficult to recoup.

I propose that this problem be minimized by applying to Medicaid the Medicare requirement that HMOs submit interim estimated cost reports and enrollment data on a quarterly basis.

2. Improved Accountability of Health Maintenance Organizations (HMOs)

The Subcommittee's study of prepaid health plans revealed that many of Medicaid HMOs had inadequate ongoing systems for furnishing the kinds of records and data needed to provide accurate cost data and other information capable of verification by auditors for cost determination purposes. Such information is not only essential for purposes of rate negotiations but is also needed to assure that the members of an HMO actually receive the services they require and need.

I propose that we:

A. Require the government to determine if the HMO is a nonprofit corporation, sole proprietorship, partnership (including limited partnerships and joint stock companies), for-profit corporation or trust. For partnerships the government will review the partnership agreement and for corporations the articles of incorporation and by-laws. The legal and operating name of the HMO will also be determined.

B. Require the name and business address of the sole proprietor; all partners in a partnership having an interest of 5 percent or more of the total equity to be noted and the officers and directors of the corporation and in the case of for-profit corporations, individuals having 5 percent or more of total outstanding securities, excluding nonvoting shares of stocks or bonds.

C. Require the chief executive of the HMO, sole proprietor or managing partner to certify in writing whether the HMO purchases or leases services, equipment or supplies from an entity with whom the HMO or any of its principals have an ownership interest, includnig any interest of immediate relatives of these principals.

D. Require such individuals to certify, to the best of his knowledge, (1) whether any officer, director or person with an ownership interest in the HMO also has an ownership interest (excluding nonvoting share of stocks or bonds) of 5 percent or more of the equity of any entity furnishing services or supplies, (2) whether there are any common officers, directors or partners, and (3) whether the HMO has financial or management interests in other institutions participating in the program, and the extent of such interest in each institution.

The government may, however, require the documentation of all partners in a partnership, or if a corporation, all officers and directors, the resident agent and all shareholders, where it has knowledge or reason to believe that a group of related persons, each owning less than 5 percent of the total equity in the provider and/or related HMO, could assume effective control of such provider or related HMO.

3. Enrollment

The Subcommittee investigation found a number of PHPs hired sales personnel to go door-to-door in the poverty areas of California in an effort to enroll Medicaid beneficiaries. In the process, numerous abuses and misrepresentations took place.

I recommend:

A. Prohibiting door-to-door solicitation except for the disabled or homebound at their invitation for any federally-approved HMO;

B. That the State agency shall offer beneficiaries a balanced presentation of the various health service delivery options to potential Medicaid enrollees;

C. That persons who lose their eligibility for Medicaid benefits shall be given the option of continued enrollment on an individual basis; and

D. Clarifying the current ambiguity between Medicare and Medicaid programs by adopting the Medicaid requirement that no more than 50 percent of the enrollees may be covered under either Medicare or Medicaid.

4. Recertification

There is presently no provision for re-certification of HMO's once they are qualified. I recommend that the Public Health Service qualification of HMO's be limited to three years. Every three years or upon 30 days notice during the three year term, an administrative hearing shall be held to review continued certification, which could be terminated for reasons of poor quality of care, financial instability or violations of law and regulations. I further recommend that such a re-certification shall be within 60 days of any Public Health Service finding of non-compliance unless the Secretary determines the non-compliance not to be substantial enough to warrant such a re-ceritfication hearing.

5. Grievance Procedures

The Subcommittee found that there was no formal mechanism for handling grievances and that the records of complaints by recipients were sometimes misplaced or destroyed.

I am recommending that the Public Health Service be required to assess the adequacy of the HMO's grievance procedures during its recertification reviews and at the same time review any grievances that have been filed with the HMO to determine if they show any patterns of abuse of patient rights or serious deficiencies in the HMO.

6. Percentage Fee Arrangements

The Subcommittee found that PHP's paid for management, computer, accounting and other services to related and non-related entities on the basis of a percentage of the plans' gross receipts from the Medicaid program. These percentage fees bore no relationship to fair prices. In addition, the Subcommittee found that some plans agreed to pay to brokers who could deliver large numbers of union local members a percentage of the gross receipts accruing from such new business.

Such arrangements are wrong. They unnecessarily increase costs to the HMO and they should be prohibited.

STATEMENT OF HON. DANTE B. FASCELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairmen and members of the Subcommittee, I am pleased to have this opportunity to support the Medicare-Medicaid Anti-Fraud and Abuse Amendments. I commend the Subcommittees for your rapid and joint attention to a most pressing national problem.

As pointed out by many of our colleagues, by responsible members of the press, and by my own constituents, the Medicare-Medicaid programs have been, and still are, subject to much abuse.

There have been many cases reported of exaggerated medical costs, unnecessary diagnostic tests, unnecessary treatment, kickbacks, and useless referrals. All of these practices and more are continuing to drain our present Federal health payments programs and, ultimately, our national Treasury.

These practices cost more than dollars, however. Instead of providing health care services to those most in need, medical facilities and personnel are often needlessly wasted on duplicated services and on improperly treating or overtreating those who need little or no treatment. Many cannot receive the treatment they need because our health care systems are already overcrowded; others, because of the increased costs of medical care caused in part by such overcrowding, are often priced out of the health care they desperately need. Further, honest and efficient medical facilities and personnel must bear the brunt of criticism aimed at the disreputable ones.

These abuses must stop and it is our responsibility—as the creators of the Medicare-Medicaid programs—to strengthen the capability of the Government to detect, prosecute, and punish those who defraud and those who abuse such programs. Thus, I have joined in sponsoring the legislation before you.

It would be pointless for me to reiterate in detail the provisions of the Medicare-Medicaid Anti-Fraud and Abuse Amendments for you are well acquainted with them. I would, however, like to emphasize that the proposed Amendments are not a magic wand that will instantly and easily solve the abuses we have encountered. There is no ready answer to the problem. Rather, this legislation will provide the Government with the authority to begin dealing with massive fraud and abuses found in our Federal health payments programs. And it is hoped that with a greater degree of interdepartmental unity and just plain hard work, we can put an end to such fraud and abuses once and for all.

Thank you.

STATEMENT OF HON. RICHARD H. ICHORD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. Chairman, I am pleased to have the opportunity to submit testimony in support of H.R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments. Widespread public concern in this regard can be traced, perhaps, to the televising early last year of laboratory representatives offering blatant kickbacks to individuals posing as doctors and to the well-publicized "sting-like" operation of the Senate Committee on Aging in which Members, posing as patients in "Medicaid mills," received poor and unneeded care time and again. I submit, however, that fraud and abuse has been rampant in the Medicare and Medicaid systems for a far longer period of time, and that the fraudulent practices uncovered by these investigations are widespread and a great cause of concern.

Abuse of the medical assistance programs has been called "a massive, institutionalized, organized white collar criminal conspiracy" and, with the advantages of newly-gathered information and retrospect, it seems to me that we have made it all to easy. The complexity of the Medicare and Medicaid programs, the diverse and massive number of regulations, and the previous lack of investigative personnel almost encourage these fraudulent practices. In the entire State of Missouri there are only seven investigators to handle Medicaid abuse complaints, a staff that Missouri officials say should be increased at least 100% in order to achieve optimum results. Nationwide investigations are equally understaffed.

It is particularly distressing, then, that recent and partial investigations have uncovered such a vast array of program abuses. Duplicative physician and laboratory bills, as well as billing for services that were never provided, are commonplace. Factoring arrangements and kickbacks to laboratories, landlords, and doctors are practiced with almost impressive sophistication. Pharmacies have been found to charge for the more expensive brand-name drug when the cheaper one was actually provided and to charge for a larger quantity of the drug, and nursing homes have siphoned an estimated $70 million from Medicaid alone in the last five years. It is estimated that this abuse adds up to $1.8 billion of the $15 billion program each year.

Mr. Chairman, I resent this waste for many reasons. I resent the inadequate, unnecessary, and negligent care that many Medicare and Medicaid patients consequently receive. I resent the bad light that this abuse by a minority casts on the integrity of the conscientious majority of health care providers. And I am particularly angered by the inexcusable waste of taxpayers' money. In a time when our needs so drastically outweigh our resources, idle debate of excessive federal spending is not enough. H.R. 3 strengthens existing program penalties and provides new means to assist federal and state officials in their enforcement efforts. It will help produce the valuable medical assistance originally intended by the programs. It will also drastically reduce this great financial waste which we cannot afford and, for these reasons, it has my enthusiastic support.

As a co-sponsor of this vitally needed legislation, I urge action by the Subcommittee on this bill. It is time that we insure that the vitally needed Medicare and Medicaid programs work for the people intended rather than as a welfare program for the unscrupulous.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., March 17,1977.

Hon. PAUL G. ROGERS,
Chairman,
Subcommittee on Health and the Environment,
Rayburn House Office Building.

DEAR PAUL: I am enclosing my statement concerning the legislation to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs.

I request that my remarks be included in the record of the hearings which were recently held.

With best wishes, I am

Sincerely,

WILLIAM LEHMAN,
Member of Congress.

STATEMENT OF HON. WILLIAM LEHMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman, I wish to express my full support for the goals of this legislation, which are to detect, prosecute and punish fraudulent activities under the medicare and medicaid programs. It is may hope that the efforts of the Subcommittee on Health and the Environment of the Interstate and Foreign Commerce Committee and of the Health Subcommittee of the Ways and Means Committee will lead to a restoration of the faith of the American people in our health care programs.

While I heartily endorse your efforts in fighting fraud, I wish to address the possibility of the prevention of such abuses. Safeguards and stringent penalties may do much to discourage fraud, but I believe there are changes which can be made in the way Medicare and Medicaid are administered, which will reduce the opportunities for fraudulent activities.

We have developed a program, namely, Medicare, which is difficult to administer. Without substantive reform of this program, it will continue to be subject to abuses. Payments often must pass through several hands before arriving at their final destinations, and the amounts of claims which are determined to be reasonable charges leave much room for dispute and perhaps dishonesty.

My office receives an incredible number of complaints about the administration of the Medicare system. I have discussed these problems at great length with patients, doctors, carriers and my fellow legislators. I have come to the conclusion that the imposition of a fixed fee schedule is one possible solution. I also believe that the health provider should deal directly with the carrier or intermediary on a basis of 100% payment for treatment rendered to a beneficiary.

I realize of course that these ideas will not be simple to implement. I am encouraged by initiatives which have been taken by the present administration to try to halt the escalating costs of hospital care. We need cost ceilings and fixed fees.

The legislation which you are now considering is an important start. It will help clean up these very important programs. I only ask that we not stop or slow down our efforts to make these programs truly workable. Fraud and abuse will remain a constant threat unless we tighten up our procedures for efficient administration.

American College of Nuclear Physicians,
Washington, D.C., March 4, 1977.

Hon. Dan Rostenkowski,
Chairman, Subcommittee on Health, Committee on Ways and Means,
Longworth House Office Building, Washington, D.C.

Dear Mr. Chairman: The American College of Nuclear Physicians (ACNP) wishes to offer supporting comments on H.R. 3, which is currently being considered by your committee.

For your information, the ACNP represents 1,000 nuclear physicians and scientists engaged in the practice of this particular specialty. Nuclear medicine is defined as that field of medicine which uses radioactive drugs for the diagnosis and treatment of disease.

The College has supported Senator Talmadge's identical measure (S. 143) on this subject, and we offer our support of your measure. We wish to cooperate with your efforts to secure an expeditious passage of H.R. 3. We strongly believe that this bill will add strength to the Government's capability to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs.

If we may be of assistance to you with regard to any legislation or Federal programs affecting nuclear medicine, please do not hesitate to contact us.

Respectfully,

Kenneth L. Nicolas.

Statement of Bert Seidman, Director, Department of Social Security American Federation of Labor and Congress of Industrial Organizations

The AFL–CIO appreciates the opportunity to submit to the two House Subcommittees on Health our views with respect to H.R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments to the Social Security Act.

The AFL–CIO strongly supports the provisions of H.R. 3 aimed at curtailing fraud and abuse. However, we have some reservations with respect to the modifications in the existing Professional Standards Review Organization provisions.

First, we will comment on the fraud and abuse amendments.

FRAUD AND ABUSE

It is indeed unconscionable, deplorable, avaricious, greedy or whatever adjectives the subcommittees consider applicable to medically exploit poor people at the taxpayers' expense. We are, therefore, in full accord with Section 2 of the bill which strengthens the ban on so-called "factoring" agreements.

With respect to Section 3 requiring disclosure of information, upon request, of ownership and conflict of interest business transactions between interested parties, we do not think the bill goes far enough.

Many physicians have invested in proprietary hospitals and nursing homes in which they admit their own patients. They invest in medical laboratories to which they send their specimens. Some even buy generic drugs, repackage them under a private trade name and then prescribe their own trade name drug to their patients at substantially higher cost.

We feel such conflict of interest transactions should be prohibited and not just disclosed. Doctors should be prohibited from engaging in such activity. Doctors would still be free to invest in hospitals, nursing homes and medical laboratories but not in those to which they refer, or which provide services for, their own patients.

With regard to Section 4, we support the provisions for penalties for providers or suppliers for defrauding Medicare and Medicaid. We oppose, however, the provisions for penalties to beneficiaries or recipients. We hold that health care is a right and not a privilege. We do not believe that mistakes or ignorance by patients as to their entitlement to Medicaid benefits should in any way be equated with fraud and abuse by providers. When considering the difficulties and abuses they experience in Medicaid mills and other settings, we find abhorrent the idea that anyone could be sent to prison for up to a year for seeking relief from pain and suffering even though they were not Medicaid entitled.

If a person who is eligible for Medicaid "abuses" the program by seeking unnecessary services, the provider must be held to account. It is the provider who determines the need for the service and it is only the provider who benefits from the transaction.

We do not know whether fraud and abuse accounts for one, two, three or even five percent of the expenditures for health care. No doubt it is significant. However, no one should be under any illusion that even complete elimination of fraud and abuse would contain the escalation of health care costs.

This escalation is primarily related to the unstructured way in which health services are delivered and the perverse incentives of the fee-for-service system which provide higher income to physicians for more services and higher cost procedures. It is also related to cost reimbursement of hospitals where hospitals have no incentive to contain costs.

Another cause of medical cost escalation is that professional, financial and personal incentives are skewed toward highly technological, but often less cost-effective, care. The physician attains far more prestige practicing specialized technological care than practicing general or family medicine and his income per hour for hospital work is three times more than for office work. Doctors, therefore, tend to concentrate on high cost specialized care that helps about one percent of the population, rather than lower cost basic care that helps many. High technology care is not bad or unnecessary. In fact, it is care of the highest possible quality and is sometimes needed. However, if health care expenditures were channeled into primary care emphasizing maintenance of health, it would not only be far more cost-effective, but also save many more lives. There would be fewer medical miracles but also fewer deaths.

In the next five years, the cost of health services will double and could exceed ten percent of the gross national product if nothing is done about enacting a national health insurance program. According to the Congressional Budget Office Federal expenditures for Medicare and Medicaid will total $57 billion in 1981. The AFL–CIO has long been convinced that only by establishing a national budget for health expenditures can these escalating national and federal costs be contained.

Your Subcommittees have indicated that statements are to be confined to issues relevant to fraud and abuse and not to national health insurance. However, the Health Security bill does directly relate to fraud and abuse because the Corman-Kennedy bill (H.R. 21 and S. 3) would establish a budget for medical services in every health service area. With a fixed amount available for physicians' services, if some doctors defrauded or abused the programs, they would be robbing other doctors and not the Federal government nor the patient. Doctors would have the incentive to police themselves.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSROS)

The medical profession is unique in that it has been given the authority by law to regulate itself. While we recognize that the PSRO can perform a useful technical function, there is no reason for the Secretary to turn over to the PSROs his present responsibilities for reviewing the cost and quality of medical care.

The delivery of health care is a monopoly of the medical profession. The medical profession is unique in that physicians not only supply health services, but also create the demand for services. The AFL–CIO is opposed to strengthening the monopoly position of the doctors. For this reason, the AFL–CIO opposes the enactment of Section 5 which would enhance unduly and inappropriately the present powers of the PSROs.

Admittedly, only doctors are qualified to judge the quality of care and whether care has been rendered in the most appropriate manner. The AFL–CIO strongly suggests that doctors be hired by the Medicare, Medicaid and maternal and child health programs to check on the performance of the PSROs. Such physicians should be full-time employees of these respective programs and would, therefore, be responsible to the program and not to the private entrepreneurial interests of the medical profession.

Section 6 would give the General Accounting Office (GAO) subpoena power over its monitoring, review and oversight activities with respect to federal programs. The AFL–CIO favors this provision.

The AFL–CIO also strongly supports Section 7 of the bill which would suspend practitioners from the Medicare and Medicaid programs who are convicted of criminal offense related to their involvement in these programs for such period as the Secretary or state agency deems appropriate. However, it should be noted that practitioners can readily avoid the law's intent by refusing to participate in these public programs and by restricting their practice to private patients. The AFL–CIO would, therefore, go even further. We propose that such practitioners' licenses to practice medicine should be suspended.

The AFL–CIO favors Section 9 providing for federal access to the books of providers of Medicaid services. We do not favor Section 10 which would allow the states 75 percent of federal matching money toward the cost of operating a Medicaid claims processing and information system if explanation of benefit information is only provided to a sample group of Medicaid beneficiaries. We believe patients can be helpful in detecting fraud and abuse if this information is supplied to all Medicaid patients.

In conclusion, the AFL–CIO supports the fraud and abuse provisions of H.R. 3 but opposes amending the law to strengthen the monopoly power of the medical profession by giving the Professional Standards Review Organizations more authority.

American Institute of Certified Public Accountants,
Washington, D.C., March 11, 1977.

Hon. Paul G. Rogers,
Chairman, Subcommittee on Health
and the Environment,
Committee on Interstate and Foreign Commerce,
U.S. House of Representatives,
Washington, D.C.

Hon. Dan Rostenkowski,
Chairman, Subcommittee on Health,
Committee on Ways and Means,
U.S. House of Representatives,
Washington, D.C.

Dear Chairmen Rogers and Rostenkowski: The Committee on Health Care Matters of the American Institute of Certified Public Accountants (the Committee) is providing the following comments on H.R. 4211, "Uniform Accounting

System for Medicare and Medicaid" for inclusion in the hearing record on H.R. 3. These comments are offered in light of the significance of the proposals in H.R. 4211.

The Committee on Health Care Matters is made up of eleven members of the profession each of whom has had major responsibilities in accounting matters related to the health care field. As part of its responsibilities this Committee studies significant federal health care legislation. The Committee has given considerable attention to recent proposals to establish uniform accounting systems for health care institutions. Accordingly, the attention of the Committee was drawn to H.R. 4211. This bill would:

"Amend the Social Security Act and the Public Health Service Act to require the use of a uniform functional accounting and statistical system and the making of uniform reports by health services institutions under the medicare and medicaid programs."

Of particular interest to the Committee is the provision, within H.R. 4211, which would amend Section 1533(d)(2) of the "National Health Planning and Resources Development Act of 1974", P.L. 93-641, to require the Secretary of Health, Education and Welfare to establish:

"A uniform functional accounting and statistical system for health services institutions. Such a system shall include—

(A) Uniform accounting practices;

(B) A uniform functional chart of accounts, including uniform definitions of specific accounts and (as appropriate) subaccounts, a uniform numerical coding system of such accounts and subaccounts, and a uniform classification of expenses within such accounts;

(C) Uniform statistical measures of productivity;

(D) Uniform methods and statistical measure for cost accounting and cost allocation among accounts;

(E) A uniform cost and statistical reporting system; and

(F) A uniform discharge abstract and uniform billing system"

The Committee understands it to be the objective of the proponents of H.R. 4211 to secure accurate, comparable data so as to improve the analytical and decision-making capabilities relating to health care costs and health care policy. Appropriate functional cost reporting is a key to effective costs control in health care institutions, just as it is in any other industry.

We are aware that, under present reimbursement programs, variations in the information contained in Medicare and Medicaid cost reports do exist. These variations are not due to a lack of uniform accounting, rather, they are due to the requirements of Medicare and Medicaid reporting. Comparative cost information can better be obtained through requiring uniform reporting by function, both of costs and units of service. This kind of reporting does not presently exist under Medicare and Medicaid programs. H.R. 4211 appears to call for such reporting and, in this connection, represents a major step toward correcting certain deficiences in present reimbursement cost reporting.

However, the bill contains one specific provision, Section B, which we suggest is unnecessary and could be extremely costly to implement. Section B would establish and mandate the use of "a uniform functional chart of accounts * * *". From a technical point of view a "uniform functional chart of accounts" is not necessary for several reasons, namely:

Such reporting can be generated if uniform cost determination methods are prescribed. The reliability of such data is not predicated upon the use of a uniform functional chart of accounts.

Further, uniform functional cost reporting can be accomplished in a number of different ways depending upon the nature of existing accounting systems and current management information requirements. To specify a uniform chart of accounts would preclude the opportunity for each institution to determine the most cost-effective way to achieve the desired reporting.

Also, although the Internal Revenue Service and the Cost Accounting Standards Board have recognized the need for financial and other information to be reported on a uniform basis, neither has found it necessary to require the use of a uniform chart of accounts.

Assuming the elimination of Section B, it may be necessary to clarify Sections A, C, D and E to ensure that these sections are adequate to support what we conceive as the intended uniform functional cost reporting requirements. For example, Section A requires that the system provide for "uniform accounting practices" while Section D requires that "uniform methods and statistical measure for cost accounting and cost allocation among accounts" be established. What may be desirable, would be a consolidation of Sections A and D to provide for a uniform method of cost accounting for health institutions, i.e., "uniform accounting practices that will enable statistical measures for cost accounting and cost allocation among accounts." Upon reflection additional opportunities for clarification may become clear.

Finally, we understand that a purpose of H.R. 4211 is to provide cost information on a uniform basis so as to permit the adoption of measures aimed at cost control or containment. We wish to make clear, however, that any accounting or reporting system in and of itself will not, and cannot, generate cost reductions nor will it necessarily provide all of the information needed to do so.

We would be pleased to meet with you, Chairman Moss, and members of your staffs to elaborate further on our comments.

Sincerely,

Roscoe L. Egger, Jr.,
Chairman, Federal Government Executive Committee.
William Freitag,
Chairman, Subcommittee on Health Care Matters.

Not.—See also later communication from AICPA at p. 498.

American Osteopathic Hospital Association
Park Ridge, Ill., March 2, 1977.

Hon. Dan Rostenkowski,
Chairman, Subcommittee on Health, House Ways and Means Committee,
Longworth House Office Building, Washington, D.C.

Dear Mr. Chairman: This correspondence presents the views of the American Osteopathic Hospital Association on the bill H.R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments. We would be most appreciative if these remarks could be made a part of the hearing record on this legislation.

The 204 osteopathic hospitals across the country represent an important community resource. Many of our hospitals are located in rural or semi-rural areas and provide a very necessary community health service. Given the recently disclosed abuses in both the Medicare and Medicaid programs, osteopathic hospitals believe a sincere and effective attempt at monitoring the programs on a coordinated basis is necessary.

Last year, legislation established the Office of Inspector General in the Department of Health, Education & Welfare. The AOHA supported that legislation and continues to support the concept of centralizing the fraud and abuse effort.

While this Association recognizes that hospitals have generally not been responsible for reported instances of fraud and abuse, we also recognize that it is the responsibility of the entire health profession to assist the government in halting such activities. The ultimate beneficiaries of such activities will be the patient population, since it is they who eventually pay the bill.

Osteopathic hospitals are deeply concerned with the rising costs of health care. Fraud and abuse represent only one component of these rising costs, but it is a component with which the federal government can deal directly.

This Association has long expressed the belief that the most appropriate role for government in the delivery of health care is that of catalyst and supporter. However, this is one of the few areas in which we believe the federal government can and should become directly involved since the problem is one which crosses state lines and is one which can be dealt with more effectively in a centralized location.

This Association therefore strongly recommends the early enactment of H.R. 3.

We appreciate the opportunity to present these comments and stand ready to provide any additional information you require.

Sincerely,

Michael F. Doody

Statement of National Council of State Public Welfare Administrators, American Public Welfare Association

The National Council of State Public Welfare Administrators of the American Public Welfare Association welcomes the opportunity to review and comment on H.R. 3, the Medicare-Medicaid Anti-Fraud Act. The Council represents state welfare agencies, most of which have responsibility for administration of the Medicaid program.

THE IMPORTANCE OF FRAUD AND ABUSE

The Council is in substantial agreement with the objective of the legislation: to curb fraud and abuse in Medicare and Medicaid. We do, however, have some concern with the emphasis being placed on this aspect of government health financing programs. On the one hand, there is a vast difference between the premeditated activities characteristic of fraud and the less definable activities of abuse. The strategies utilized to control either problem are thus likely to be far different from one another; this legislation tends to prescribe the same remedies for both. On the other, while no one would dispute the serious nature of fraud and abuse, there are far more pressing problems facing the federal and state governments with regard to Medicaid. We do not believe that fraud and abuse are prime contributors to soaring health and thus Medicaid costs. Since 70% of Medicaid dollars is consumed by institutional services, we believe that far more sweeping changes are necessary in that sector—particularly in methods of reimbursement. The Council urges the prompt consideration of comprehensive changes in Medicaid which would allow us to control costs. We do not believe that piecemeal legislation which deals with a really secondary contributor to program costs—fraud and abuse—is sufficient.

This is not to say that we do not support several sections of the proposed legislation. In particular, we support sections of the proposed legislation covering financial disclosure by providers in Medicare and Medicaid; federal review of provider books; increasing the penalty for fraud to a felony; authorization for states to remove providers convicted of fraud from the Medicaid program; and allowing the explanation of Medicaid benefits information to be furnished to a sample, rather than all recipients. For the most part, these provisions give states greater flexibility to control both fraud and abuse.

FACTORING, SHARED HEALTH FACILITIES

Other provisions in the proposed legislation would ban factoring in Medicaid and Medicare. Regulations have already been published by SRS which would accomplish this purpose. These have already been challenged in court. The problem lies in the enforceability of this requirement. It is extremely difficult to both accurately define factoring and eliminate its practice altogether, based on whatever definition is ultimately adopted. A far more viable alternative is to assist the few states where factoring exists to improve their claims processing systems—without whose deficiencies factoring could not survive.

Similar problems emerge with the definition of shared health facilities. It is impossible to sharply define and segregate these facilities from other forms of group practice. Here again the problems lie in adequate review and monitoring by states—a problem far broader than Medicare or Medicaid. States should be encouraged to improve their monitoring capabilities (e.g. MMIS), rather than attempting to focus on one very specific set of offensive providers.

THE ROLE OF PSROS

The most troublesome features of the proposed legislation are, however, the several provisions dealing with PSROs. The charge of PSROs is to both assure quality of services and, in doing so, curb inappropriate expenditures. Clearly the states have a similar interest in promoting both objectives; they have a particular stake in cost containment. The bill would expand the scope of authority of PSROs and at the same time severely limit the state review and monitoring of their activities. States would, in effect, be prohibited from undertaking any reviews that the PSRO has already conducted. Notwithstanding the need to curb duplicative expenditures, there is no doubt that some similar efforts of the states and PSROs are necessary. A number of issues regarding PSROs remain to be resolved (see attached paper). Thus it is premature to grant such extended authority until these issues are addressed and experience with PSROs thoroughly evaluated. The extension of trial period to 24 months; the designation of qualified status on the basis of hospital review alone; the involvement of PSROs in nebulous "shared health facilities"; the designation of PSRO findings as conclusive; and the prohibition against concurrent reviews all vest a great deal of power in PSROs when they remain largely unproven. Some states have noted, for example, that PSRO review of hospital outpatient facilities, another common source of Medicaid abuse, is notably poor. In addition, as Beverlee Myers pointed out in her testimony on September 22, 1976 before this Subcommittee, it is not at all clear that PSROs are cost effective.

The Council's concern with these several provisions is shared, moreover, by other state groups examining the Medicaid program. The National Governors' Conference adopted the following position at their recent meeting, February 28:

"The law and regulations should be changed to allow states to contract with PSROs and to review and approve proposed PSRO policies to insure that these functions are reasonably accountable to states."

Preliminary recommendations of the New Coalition's[1] Task Force on Medicaid also include several provisions relation to increased state review and monitoring of PSROs. Virtually state and local bodies with an interest in Medicaid recommend increased state interaction with PSROs.

Therefore, the Council recommends that Section 5, with exception of parts (b) and (e) governing PSRO financing and data exchange, be eliminated until more evidence concerning the efficacy of PSROs is obtained.

We thank the Subcommittees for the opportunity to comment on H.R. 3 and are available for any further assistance.

AMERICAN PUBLIC WELFARE ASSOCIATION
Washington, D.C., January 21, 1977.

Subject: PSROs and medicaid: A summary of recent developments.

OVERVIEW

The passage of P.L. 92–603 saw adoption of a major new program designed to assure the quality and appropriateness of medical care. Section 249F of the law provided for the establishment of professional standards review organizations (PSROs), state-based bodies of professionals who would monitor the quality of care.

The distinct task of PSROs is to certify that all Medicaid, Medicare, and Title V admissions to health institutions, specifically hospitals and nursing homes, are medically necessary. PSROs are charged withe the development of criteria to determine the appropriateness of admissions, length of stay, and other aspects of health services. Ultimately the organizations are to assume homes, are medically necessary. PSROs are charged with the development of PSRO policy is vested in the Bureau of Quality Assurance (BQA), an arm of the Health Services Administration, which is also responsible for reviewing progress and distributing funds. All development and operating costs of PSROs are covered by the federal government.

Most states are divided into several PSRO regions, although some organizations have statewide authority. In states with multiple PSROs, an advisory council has been designated to coordinate activities and assure uniform implementation. PSROs are usually formed and administered by physicians and frequently are promoted by local medical societies. At present, the involvement of other health professionals is greatly limited.

As mentioned above, PSROs are specifically designed to review the appropriateness of medical services financed by three federal (federal/state) health programs. Under a decision made by (then) HEW Secretary Caspar Weinberger, PSROs have ultimate jurisdiction and authority to determine medical necessity.[1] Under this ruling, the PSRO decision takes precedence over that of a state Medicaid program or Medicare fiscal intermediary. Thus far, PSROs have largely reviewed care in hospitals (about one-third of the Medicaid budget); eventually they will cover services rendered in nursing homes, another one-third to one-half of Medicaid expenditures. Thus, PSROs have tremendous potential to modify state and federal health expenditures (discussed in more detail below).

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[1] The New Coalition is composed of officials from the National Governors' Conference, the National Conference of State Legislatures, the National League of Cities/U.S. Conference of Mayors and the National Association of Counties.

[1] February 24, 1975.

As of June 30, 1976, some 87 PSROs had been designated as "conditional", i.e., they have been found competent and are undertaking active review. Thirty-three PSROs are in the planning stage. Thus, a substantial number of states are already working with area PSROs.

ADMINISTRATIVE CONTROLS

As presently managed, PSROs govern services financed by three different (generally independent) federal divisions within HEW: the Medical Services Administration (in Social and Rehabilitative Service); the Bureau of Health Insurance (in the Social Security Administration); and the Division of Maternal and Child Health Services (in the Health Services Administration). Coordination among these three administrative entities is frequently strained, largely because of the sheer size of the programs invloved. The Bureau of Quality Assurance must work with each one to assure coordinated implementation of PSRO policies and activities.

The states are one level removed from the workings of the Bureau of Quality Assurance and the Medical Service Administration.[2] Many states have been skeptical and apprehensive of PSRO involvement in Medicaid administration. Some believe that since PSROs are dominated by physicians that decisions will be biased in their favor, i.e., the states will be paying for services that are not medically necessary. Related to this potential problem is the overall concern that PSROs, independent of state authority, will exercise considerable control over state Medicaid services and payments. However, the federal government has made a strong commitment to PSRO review of services, thus most states are preparing their systems to accommodate their activities.

RECENT POLICY ISSUANCES

1. *Fiscal Penalties in Utilization Review and PSROs.*—One of the most controversial policies in Medicaid is the fiscal penalty associated with utilization review activities. Basically, if a state fails to demonstrate that a number of required procedures have been performed, it is subject to a stiff penalty (loss of federal funds) (section 207 of P. L. 92–603, section 1903(s) of the Social Security Act). Eventually, most of the required reviews will be assumed by PSROs. In the interim, SRS has issued guidelines under which the penalty will (or will not) be assessed. Specifically, states are relieved of making a satisfactory showing and being subject to a financial penalty in facilities where the PSRO has assumed responsibility for physician certifications and re-certifications; physician plan of care in short-stay hospitals; and utilization reviews. Note that the state's responsibility is maintained until SRS informs the state that the PSRO has assumed binding authority (see Action Taansmittal SRS–AT–76–141 (MSA), September 3, 1976).

2. *Federal Financial Participation and PSRO Decisions.*—If a state pays for services not deemed medically necessary by the PSRO, no FFP is available for those services (section 1158 of the Social Security Act prohibits FFP for PSRO disapproved services). On the other hand, a state may elect to withhold Medicaid payment for services approved as medically necessary by the PSRO where it has determined otherwise. Under these circumstances no Medicaid payment has been made and, as a result, no FFP is claimed.

3. *FFP, State Monitoring, and Continuing UR Responsibilities.*[3]—HEW has consistently urged states to monitor PSRO activities. However, no formal monitoring requirement exists. States may be involved in all stages of PSRO development. So-called "memoranda of understanding" are usually negotiated between the state and PSRO prior to designation of that PSRO conditional status. These memoranda, subject to HEW approval, detail the relationship of the PSRO to the state Medicaid program and cover exchange of information, certification, monitoring, etc. Again, these agreements are not mandatory.

HEW has recently issued guidelines with which states should monitor PSRO activity. In addition, the Department has attempted to clarify the availablity of FFP for such monitoring. Specifically, FFP is only available for those monitoring services which do not duplicate the purposes and activities of the PSRO. HEW will provide FFP for monitoring and "to assess the propriety and effectiveness of PSRO review of care provided to Medicaid patients" (SRS–AT–76–140). This policy does not preclude the state from sampling PSRO reviews, evaluating on a case-by-case basis or a variety of activities similar to the routine services of the PSRO. Clearly, some reiteration of PSRO activities is necessary to program evaluation. HEW will, however, question those evaluations used primarily to override PSRO decisions or that are virtually identical to PSRO efforts.

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[2] Information is received only from MSA; BQA has no direct control with states.

[3] See Action Transmittals SPS–AT–76–141 and 140, both issued September 3, 1976, for more detailed discussion of monitoring.

State monitoring of PSROs is encouraged to be an ongoing process, occurring at all stages of implementation—from the planning to conditional phase of 24 months—and, finally, to operational status. Monitoring is deemed to be particularly important during the conditional phase, for it is within this period that PSROs develop review expertise, data collection techniques, and experiment with various review criteria. Each state must submit a monitoring plan to SRS prior to implementing any evaluation activities. It should include comments from the PSROs and facilities involved (the plan may be referenced or included in the memorandum of understanding). Implementation of the plan occurs after SRS review and approval. Once the PSRO becomes fully operational, the state is expected to reduce detailed monitoring activity (such as case-by-case review) and to rely on aggregate statistics. Information and data from the PSROs is expected to be made available to states to assist them in all phases of program monitoring.

4. *Grievance Mechanism.*—Both MSA and BQA recognize that differences of opinion are bound to arise between the states and PSROs. A grievance mechanism has been adopted to allow both parties to air complaints. Formal complaints from states should be based on evidence of fiscal problems stemming directly from PSRO determinations or on indications that such decisions are adversely affecting the quality of care rendered to Medicaid patients. The following steps have been adopted:

a. Informal interchange between state and PSRO; state brings questionable determinations to PSRO's attention.

b. Formal feedback and meetings at periodic intervals from state to PSRO to HEW to resolve problems.

c. State requests formal review of problems by PSRO; response or corrective action required within 30 days.[4]

d. Filing a written complaint with SRS Regional Commissioner with materials from state, PSRO, and (if included) report from any impartial review group and similar materials to the Regional Health Administrator and the PSRO. Corrective action is required within 90 days unless the state asks for a suspension of the PSRO's authority; in this case HEW will act immediately to suspend authority. Thorough documentation would be required to document the complaint including: (1) improper review determinations; and (2) detrimental impact on state Medicaid expenditures and/or quality of care. If justified, HEW will suspend binding review authority of the PSRO pending a full investigation. PSROs' determinations during the investigation are then advisory, not binding.

e. HEW reviews problems once review authority is suspended. (Note: suspension of the review authority may only occur with conditional PSROs; once fully operational, complete termination of the contract is the only option available.) Options for a conditional PSRO found deficient include: (1) restrictions on full review authority; (2) require PSRO to take corrective action; (3) continue partial suspension and advisory status until corrective measures have been taken; and (4) terminate PSRO agreement.

FINANCING

The administration and operations of PSROs is financed through individual appropriations made by BQA. Each PSRO contracts with the federal agency for a grant which, in addition to administration, covers review of ambulatory and long-term care. Review of acute hospital care is financed by two separate mechanisms, depending on whether the institution is delegated review authority, e.g., the hospital performs review for the PSRO, or the PSRO maintains review authority itself. Hospitals that have been delegated review authority may include the cost as a reimbursable expense under Medicare and Medicaid. Most institutions have performed some sort of utilization review—and been reimbursed for it—for some time, so that this does not necessarily represent a new expense for Medicaid or Medicare. For those institutions reviewed by the PSRO (so-called 'non-delegated' review), the PSRO is now reimbursed directly by the Social Security trust funds. Section 112 of P. L. 94–182 authorized the use of such funds for PSRO reviews of acute hospital care, thus removing a relatively large financial burden from the PSROs. In addition, an adjustment will be made to assure that non-delegated review of Medicaid services will be paid for by the federal government.

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[4] At this stage, a physician group impartial to the PSRO and the state may be asked to review questionable determinations.

CONTINUING ISSUES

A number of issues remain to be addressed concerning the relationship of PSROs to state Medicaid programs. Some are more pressing than others, but all are likely to emerge in the future as policy questions.

1. *Federal Financial Participation.*—The recent guidelines issued by HEW attempted to clarify the availability of FFP for utilization review and PSRO monitoring. However, some questions still exist. For example, some states have developed sophisticated utilization review programs, e.g., the Medicaid Managment Information System, and have achieved substantial progress in curbing inappropriate utilization. It remains unclear whether these activities can be sustained when PSROs are operational. This may be a particular problem in states with multiple PSRO areas. In this instance, the state's review responsibility may be fragmented if some of the PSROs are operational, while others are not. In addition, fraud and abuse detection activities may require some repetition of the PSRO reviews. More definitive guidelines are necessary to assure that states are able to maintain necessary review function and some receive federal matching payments.

2. *Exchange of Information/Development of Criteria.*—One of the principle functions of PSROs is to develop criteria and standards upon which determinations of medical necessity can be made. These criteria are generally based on recognized patterns of medical practice and, as such, extensive data is necessary to assure use of sound criteria. In addition, the PSRO must continue to receive such information from providers under its review authority. State Medicaid programs are generally faced with similar data collection tasks. A number of states have implemented the MMIS program and already have made great progress in developing sophisticated generation capabilities. Most states are currently upgrading data collection capacities. Such information is vital to utilization review, fraud and abuse detection and related activities. The problem is that in many states the PSROs and Medicaid programs are operating independently; little or no exchange of information occurs. As a result, parallel and somewhat duplicative system are being developed—clearly a costly waste of time and effort. This concurrent' development,[5] moreover, intensifies the independence of states and PSROs. (Proposed regulations were recently issued which would substantially curtail the PSRO's ability to release information to the general public—another means of isolating the PSRO from the community and state Medicaid program.) At this point, insufficient guidelines exist for the exchange of information between the states and PSROs, or, even more important, exchange of criteria. Both could gain from cooperative development.

AREAS WITH NO PSRO

The treatment of areas with no PSRO remains unclear. Some states would no doubt be able to assume review activities—they should be given the opportunity.

ROLE OF PARAPROFESSIONALS

As medical care has become more sophisticated, the role and importance of paraprofessionals has increased. PSROs are encouraged to have input from such personnel in both review and development of criteria. However, they are not required to do so. States are concerned that physicians will assume complete control of review activities and ignore the important and partly independent contribution that paraprofessionals could make.

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[5] Some states believe that development of criteria must proceed on the basis of statewide information—that the review area within the purview of most PSROs is too limited to foster adequate standards.

LONG-TERM CARE

One of the most pressing issues facing states is PSRO review of long term care services. Nursing home expenditures are phenomenally high and Medicaid agencies are concerned that the rise in costs and utlization will not diminish. The role of PSROs in this broadbased area has been specified, but with no clear indication of how such responsibilities will be executed. Here PSRO review has the potential to be extremely effective. However, there should be no question that Medicaid agencies have substantial involvement in review, monitoring and policy development. (The Bureau of Quality Assurance has, however, been hampered in implementation of long term care review by lack of support from former HEW Secretary Mathews. Many PSROs are eager to perform such reviews, particularly with some financial coverage by the Social Security Trust Fund for acute hospital care—thus releasing funds for other reviews.)

PSROS AND AMBULATORY CARE

Ultimately, PSROs are charged with review of all services financed by Medicaid and Medicare—including ambulatory care. The end of the 94th Congress saw an effort to accelerate PSRO review in that area—notably in shared health facilities or "Medicaid mills". However, some states are concerned that present PSRO review in acute hospitals is insufficient, particularly in hospitals that have a large component of outpatient services. These institutions frequently provide a substantial amount of services to Medicaid recipients and have been found practicing some of the same abuses as "Medicaid mills" (e.g. excess laboratory tests). Thus, states believe that until PSROs can perform adequate review in the first focus of operation—acute care hospitals—that other practitioners should be left to state review.

THE COST OF PSRO OPERATIONS

At this time, PSRO services are fully funded by the federal government. Some states remain concerned, however, that ultimately PSRO reviews will be financed by state revenues. This issue has drawn particular attention in states with multiple PSRO areas; theoretically the state is still responsible for some reviews and not others—depending on whether any PSROs are designated as conditional. Thus some clarification on financing is still necessary (*note:* BQA personnel have indicated such clarification is forthcoming.)

CONCLUSION

The potential for PSROs to conduct effective review of health services under Medicaid and Medicare is great. However, a number of constraints in present program administration and implementation remain to be resolved. States are largely concerned with the independent authority of PSROs—how PSROs will mesh with state Medicaid reviews. Recently two task forces reviewing the Medicaid program—one sponsored by the National Governors' Conference and one by the New Coalition—have recommended a thorough reassessment of role of PSROs in Medicaid. Thus, it is likely that some of the issues raised in the present discussion will be addressed.

Statement of the American Society for Medical Technology

The American Society for Medical Technology (ASMT) is most pleased to provide the members of the House Ways and Means Health Subcommittee with views on H.R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments.

ASMT is a national, professional organization composed of over 28,000 members engaged in the delivery of clinical laboratory services. The Society is composed of 50 constituent state societies, in addition to the District of Columbia, which hold charters granted by the national organization. The country is divided into ten regions with an average of five states per region. An elected

House of Delegates forms the governing body of the Society and when not in session, its functions are carried out by an elected Board of Directors. The Society is organized to give each member the opportunity to be an active partner in the development of standards and practices enumerated in ASMT's policies, positions, and publications.

Our membership is made up of a variety of nonphysical categories of clinical laboratory personnel including clinical laboratory administrators, supervisors, educators, technologists, technicians, assistants, and such specialists as microbiologists, clinical chemists, hematologists, immunohematologists, cytotechnologists, histotechnologists, and nuclear medicine technologists. Approximately seventy-five percent of our membership hold degrees at or above the baccalaureate level while another ten percent hold associate degrees. The remainder of the membership is composed of individuals who fall in specified categories such as students.

In addition to a membership diverse in specialty and generalist functions within the laboratory field, laboratory settings or places of employment range from private or independent laboratories, physician offices, clinics, blood banks, research institutes, to hospital laboratories—both governmental and non-governmental. Thousands, however, in fact the majority of our active members work in hospital laboratory settings throughout the country.

On behalf of our membership and in the interest of better health care delivery on a national basis, ASMT is in favor of and has previously gone on record to support the concept of national health insurance. Our Society subscribes to the basic principle that every American should be assured access to quality health care and that no person should be denied health care because of inability to pay.

In testimony on national health insurance presented before the House Ways and Means Committee in May of 1974, ASMT suggested the obvious: that any form of national health insurance adopted by the Congress will undoubtedly have a profound effect on the way health care is now delivered. In fact, close scrutiny and evaluation of our present health care system is critical in order to ensure that any form of NHI eventually developed will ensure both efficient and economical health care services available to all our citizens.

Although we continue to favor eventual enactment of a well-conceived national health insurance program, AMST recognizes that the critical problem of controlling the sharp rise in health costs has effectively slowed the drive toward some form of NHI during recent sessions of Congress. Moreover, while the current health care system contains acknowledged strengths, an examination of the Medicare-Medicaid programs since their enactment clearly demonstrates serious defects which must be eliminated before moving onto a more comprehensive health insurance scheme. It just doesn't make good sense to build upon the current health system until some of the obvious deficiencies within the system can be eliminated.

The Medicare-Medicaid Anti-Fraud and Abuse Amendments would deal directly with one of the major and most serious deficiencies extant in the two Federal health programs; to wit, fraud and abuse. We therefore applaud Congressmen Rostenkowski and Rogers for their commitment to restore a sense of order and morality in the Federal health payment programs prior to seriously considering their further expansion.

Although we understand that this legislation should not be viewed as the final solution to the problem of fraud and abuse, we do believe that expanded legislation will better equip the Secretary and in turn, his designated agents or Inspector General with the necessary tools to better detect and prosecute fraud and abuse in the Medicare/Medicaid programs. Thus, ASMT strongly endorses the intent of H.R. 3 which we believe is much needed and long overdue.

To begin to appreciate and to understand the problems involved, one need only to look to the report entitled, "Fraud and Abuse Among Clinical Laboratories;" a staff report prepared for the Subcommittee on Long Term Care of the U.S. Senate Special Committee on Aging in February of 1976. The report concluded a five-month investigation into the operation of independent clinical laboratories under Medicare and Medicaid and made the following findings:

"1. Comparatively few labs control most of the Medicaid business in the United States. In New York, 16 labs controlled 70 percent of the Medicaid business. In New Jersey a dozen labs controlled nearly 60 percent of Medicaid funds. In Illinois 26 labs control over 90 percent of Medicaid funds paid to clinical laboratories.

2. Competition for Medicaid accounts is fierce. It seems that the only way to obtain a Medicaid lab account is to offer a kickback. The greater the kickback offered the more likely the lab will be to obtain Medicaid business.

3. The average kickback is about 30 percent. This is about the figure we projected for kickbacks between pharmacies and nursing homes in the exhaustive study we completed 2 years ago. Kickbacks can take many forms from cash, gifts, supplies, long-term credit arrangements to the furnishing of supplies and business equipment. Most commonly, the technique used is the "rental" of a small amount of space in a medical center or the payment of part of the physician's overhead or payroll expenses.

4. At the root of the problem is the overgenerous fee schedules for clinical lab services. These fee schedules were established in 1967 when Medicaid went into effect and most tests were performed manually. Meanwhile lab technology has advanced rapidly in the past five years. Costs have been cut dramatically but the resulting savings have not been passed on to the consumer. Instead they have been used for "marketing" or physician inducements.

5. In order to maximize their ability to succeed in the kickback game, many labs have found ways to increase their income from Medicaid. The predominant technique is to charge for tests that are not authorized by the physician. Another common abuse is billing Medicaid for component parts of tests which should be run and paid for as a panel. Perhaps the most serious problem, was charging Medicaid patients rates two and three times what private paying patients are charged.

6. By conservative estimate we project that at least $45 million out of the $213 million (or $1 out of every $5) in Medicare and Medicaid payments to clinical laboratories is either fraudulent or unnecessary. This is a conservative estimate because a reasonable case can be made that about 50 percent of current payments are inappropriate. I cite New Jersey's experience where fee schedules were reduced by 40 percent as well as New York's analysis that lab payments could be cut in half by incorporating the principle of regional laboratory programs.

7. If laboratories in Illinois (a sample state) charged Medicaid patients what they charge private paying patients there would be an estimated savings to the State of Illinois of 58 percent of the present payment for lab services.

8. It is apparent that 42 U.S.C. 1395 and 1396 making the offering or accepting of a kickback illegal and punishable by a $10,000 fine, a year in jail or both is not being enforced by HEW or the U.S. Department of Justice.

9. In practical terms, this means that under current reimbursement, (1) any laboratory which is so inclined can bill Medicaid for tests on a patient a doctor has never seen, (2) for blood never drawn, (3) for tests never performed, (4) at a rate exceeding four times cost and, (5) twice the prevaiilng rate to private patients, (6) and in so doing violate laws and regulations of general and specific application with nearly absolute assurance that they will not be caught and prosecuted."

In order to effectively deal with the problems of fraud and abuse as outlined, the Staff's chief recommendations to the Congress were:

1. The Clinical Laboratories Improvement Act should be enacted at the earliest opportunity; and

2. The Congress should enact legislation to consolidate HEW's Medicare and Medicaid enforcement efforts. An Office of Inspector General for Health should be created to monitor Medicare and Medicaid fraud and abuse.

We believe that the Congress is to be commended for the swift action that it has taken in realizing these two rceommendations. The Office of Inspector General has been established through legislation passed last year and the Clinical Laboratory Improvement Act has already been reintroduced in the 95th Congress by Senator Jacob Javits with twenty-two cosponsors and Mr. Rogers is expected to reintroduce his counterpart measure in the House of Representatives shortly.

ASMT strongly endorses the basis intent of the Clinical Laboratory Improvement Act of 1977 and believes that it provides an excellent opportunity to focus on some of the most crucial issues related to the provision of laboratory services and their resultant costs. While unanimous agreement is unlikely within the laboratory community itself regarding the need for expanded government authority regulating laboratories and their personnel, we are convinced that there are persuasive reasons for the Congress to seriously consider enacting just such legislation concurrent with other Federal health program reforms.

ASMT specifically endorses Section 3 of H.R. 3 requiring providers and suppliers participating in both Medicare and Medicaid to disclose upon request specified ownership information and information pertaining to business transactions with related parties.

In a GAO report entitled, "A Proposal for Disclosure of Contractual and Financial Arrangements Between Hospitals and Members of Their Governing Board and Hospitals and Their Medical Specialists," the Comptroller General recommended that Congress consider amending the Social Security Act to require hospitals, as a condition for participating in Medicare, to make publicly available information disclosing (1) overlapping financial interests of the Board members and key employees, including a statement of the extent of competition involved in acquiring goods and services, and (2) the hospitals' arrangements with hospital-based specialists. The Chairman of the Senate Finance Health Subcommittee, Senator Talmadge, has announced his intention to reintroduce several Medicare reform amendments to the Social Security Act, including one which would provide that hospital-based physicians could no longer enter into percentage, lease, or direct billing arrangements for Medicare reimbursement purposes. Testimony before the Senate Finance Health Subcommittee last July revealed the tremendous drain which present reimbursement practices have on the Medicare program.

Also, according to the Special Committee on Aging's Report on Fraud and Abuse, physicians often work for clinic owners. And, since there are few requirements in any state with respect to ownership of a laboratory, most laws focus on the qualifications of the operator. It has been reported that clinic owners often hire physicians under contracts and "encourage" them to order unnecessary tests to generate income for a lab in which they might have an interest or in order to maximum the amount of the kickback they might receive from a laboratory (in exchange for sending them all the lab business of the clinic).

Therefore, ASMT would recommend that individual physicians not be exempt from the provisions of Section 3 of H.R. 3. It is our belief that individual physicians as well as other providers may have a vested interest in the form of ownership of various supply houses or independent clinical laboratories that could potentially lead to a conflict of interest.

For example, an individual physician could own a major percentage of a supply house or independent laboratory without having a controlling interest and as such, would remain free from having to disclose specified ownership information or information pertaining to business transactions with related parties.

In this regard, a recent report issued by the Comptroller General entitled, "Tighter Controls Needed Over Payments for Laboratory Services Under Medicare and Medicaid" pointed out the physicians often add substantial markups for laboratory services obtained from independent laboratories. Medicare carriers usually pay these markups because the claims either do not show where the services were performed or indicate that the services were performed in the physicians' office laboratories.

Many laboratory officials were reluctant to cooperate with the General Accounting Office because, it is said, they feared losing physicians' business if they provided information showing amounts physicians paid for laboratory services. The laboratories that cooperated did so with the understanding that the laboratories' and physicians' names would not be disclosed.

Although ASMT has no proposal or formula for reducing or containing laboratory costs, we do recommend that both the public and private sectors begin to critically examine specified ownership information and information pertaining to business transactions with related parties in terms of their possible impact on laboratory costs.

ASMT also strongly endorses Section 3(f) providing that the Secretary or any entity so designated have reasonable access to the books and records of independent pharmacies, independent laboratories, independent suppliers of durable medical equipment and renal disease facilities which pertain to the billing and payment for goods and services supplied or rendered by such entity in connection with programs established under Titles V, VIII and XIX.

Our Society believes that to effectively administer the two programs the Secretary must be equipped with the necessary tools to police them. Reasonable access to the books and and records of the above-mentioned would be an important step towards assisting the Secretary to carry out his duties and responsibilities in detecting and prosecuting fraud and abuse.

Section 4 of H.R. 3 respecting penalties for defrauding Medicare and Medicaid Programs would amend Section 1877 and 1909 of the Social Security Act. From the standpoint of the clinical laboratory field, ASMT believes that the proposed change in nature of crime from a misdemeanor to a felony together with the substantial increase in penalty should help deter individuals from committing potential abuses within laboratories. By alleviating acknowledged fraudulent practices, moreover, these stiffer penalties hopefully would also help contain the costs of laboratory services rendered through Medicare and Medicaid.

In this regard, ASMT would also endorse the proposal to limit, restrict, or suspend the eligibility of an individual under Medicaid if that individual is convicted of an offense involving fraud. And finally, the Society is pleased to see clarifying language under this Section which would strengthen the law and reduce the potential of loopholes.

Section 4 of the legislation would require the Secretary to give priority to a request made by a Professional Standards Review Organization for review responsibility with respect to services furnished in shared health facilities. The Society endorses, but with qualification, the intent of this provision. Certainly, the PSRO mechanism—the professions themselves responsible for review of their own services—should be applicable to all health delivery settings. ASMT believes, however, in view of the early stage of PSRO implementation, that it may be premature for PSROs to play a strong advocate role in the area of fraud and abuse control.

The government has defined professional standards review as: "The formal assessment by health care practitioners of the quality and efficiency of services ordered as performed by other health care practitioners in the same health care profession." The logical extension of this definition with respect to the clinical laboratory is: the formal assessment by the clinical laboratory practitioner of the quality and efficiency of services performed by other clinical laboratory practitioners in the profession of clinical laboratory medicine.

At the present time, a comprehensive system of peer review applicable to both institutional and non-institutional clinical laboratories is not operable. Thus, it does not seem prudent to give priority designation to a PSRO for review of these services in shared health facilities nor to authorize PSROs the responsibility for the conclusive final determinations of payment for specified types of health care services. ASMT is hopeful that Congress will consider in the near future the potential for all health care providers to be involved directly in the review of their own services directly within the PSRO process. In the meantime, the Society believes that the Secretary should assume the lead responsibility for review of services furnished by shared health facilities respecting their compliance with Titles XVIII and XIX of the Social Security Act.

Finally, the Society endorses Section 9 which would allow Federal access to the books of providers of services under Medcaid in the same manner that such access is presently provided to state agencies. Freedom of information is essential to the investigation by the Inspector General of potential program abuses.

In conclusion, the American Society for Medical Technology wishes to pledge its cooperation with the Committee to curb, through revised and expanded law, abuses of the Federal health programs. We believe H.R. 3 is a substantial reflection of commitment to the Medicare-Medicaid reform effort.

STATEMENT OF THE AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS

The American Society of Clinical Pathologists appreciates the opportunity to submit the following comments on H.R. 3, the "Medicare-Medicaid Fraud and Abuse Amendments":

The American Society of Clinical Pathologists is a non-profit, educational and scientific medical specialty society, representing nearly 23,000 medical laboratory professionals, including approximately 6,500 Board-certified pathologists. As such, we are vitally concerned with the problems of fraud and abuse of the Medicare and Medicaid programs, and strongly support efforts by the Congress to control such activity.

As you know, in the past year, fraud and abuse in the clinical laboratory has received a sizable amount of attention, in the press, in the Congress, and in the medical profession. Because of our commitment, and the commitment of our entire membership, to the delivery of quality laboratory services, and quality health care, it is our desire to see that the small number of unscrupulous laboratory directors and practitioners are identified and punished, so that the entire profession is not irreparably damaged by the results of their activities. We do wish to state, at the outset, that these dishonest practitioners are in the minority, and the vast amount of publicity given to their activities is unfair to the honest professional who is working to find the most effective treatments for disease, to provide the best in care to his patients, and to uphold the highest standards in his medical practice. As Chairman Rogers pointed out when he introduced H.R. 3, fraud and abuse by any segment of the medical profession damages the reputation of the entire profession. For this reason, the American Society of Clinical Pathologists applauds the efforts of the Committees to develop legislation to combat the activities of those who defraud and abuse the Medicare and Medicaid programs.

While we strongly support H.R. 3 in principle, we have some concerns regarding specific provisions of the bill.

It is our primary concern that a law intended to rid the medical profession of unscrupulous providers not work an undue hardship on the dedicated, honest and hard-working practitioners who are in the majority in the profession. The law must contain measures to protect the honest physician. Section 3 of H.R. 3, which deals with disclosure of ownership and financial information, would require such disclosure of virtually every health care facility and practitioner in the nation except the individual physician in a solo practice. The burden of paperwork that this provision would place on the government, as well as on those required to comply, is phenomenal! This amount of wasted time and effort, when medical facilities are already overburdened, is unthinkable. We propose that Section 3 of the bill be amended to indicate that disclosure of ownership and financial information is required of only suppliers and providers who are associated with entities determined to be "shared health facilities".

Also in regard to Section 3, we suggest that there be a clarification in subpart (a)(1)(F), as to the specific meaning of "reasonable access" to books and records in such entities as an "independent pharmacy, independent laboratory, independent supplier of durable medical equipment, or renal disease facility". We are seriously concerned about the implications of this provision in the confidentiality of the physician-patient relationship.

We believe that the definition contained in H.R. 3 of "share health facility" is too broad, and could encompass any form of group practice. The financial limits provisions are not realistically drawn, given the present system of Federal reimbursement. A physician could receive from the Federal government a large single payment, reimbursing him for several months' billings, and if this payment exceeded the $5,000 monthly limit, he would be unfairly subjected to the reporting provisions of this legislation. The intent of the legislation to combat fraud in the Medicare and Medicaid programs is not served by this all-inclusive provision. If the financial limits provisions were deleted, the definition would still include the so-called Medicaid mills, which are the target of this provision, because they often employ an individual to manage substantial aspects of the health care delivery system, or to make available supporting staff, and this individual is compensated on a percentage basis. If these provisions were deleted, the bill would not subject the bulk of group practitioners to the reporting provisions.

We want to conclude by pledging the full support of the American Society of Clinical Pathologists in efforts to halt fraudulent and abusive practices. We abhor such activities, and pledge that all who conduct such practices should be punished to the full extent of the law.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

The American Society of Internal Medicine (ASIM) supports the intended purpose of H.R. 3. Like the Congress, we are concerned about fraudulent and abusive activities under federal health programs, or indeed, under any health programs. We are prepared to endorse and assist governmental efforts to identify such activities in order to punish the perpetrators appropriately.

However, we do object to certain provisions in the bill that would permit broad powers of investigation into areas where there is no indication of fraud or abuse. We question whether investigation into these areas would be cost effective and, therefore, support reasonable restrictions on investigatory powers as outlined below.

We also have concerns relating to PSRO review of ambulatory care and the annual report on PSRO activities to Congress.

SECTION 3(A)

This section would require any provider or supplier of services under Medicare of Medicaid to comply with any requests from the Secretary of DHEW or Comptroller General for specified ownership and financial information.

First of all, we believe it unnecessary that both the Secretary and Comptroller General be empowered to request this information. It would be better for this authority to be vested in the Secretary's office leaving the Comptroller General's office to fulfill its originally intended function of monitoring government agencies' implementation of laws enacted by Congress.

We believe it is wrong to give the Secretary unlimited authority to make such requests without prior demonstration of "probable cause". It could be grossly unfair to make the great majority of providers and suppliers who are honest comply with time consuming, costly requests for information if there is no evidence indicating possible fraud or abuse. Given the powers granted the recently created office of Inspector General of DHEW, it should not be difficult to show "probable cause".

We recommend that the Secretary be required to demonstrate "probable cause" prior to requesting the specified information.

SECTION 3(B)

This section provides a definition for "shared health facilities" in order to facilitate identification of "medicaid mills". Such facilities are subject to the information disclosure requirements discussed above and assigned top priority for ambulatory care review by Professional Standards Review Organizations (PSROs).

Proposed Section 1125(3)(B) of the Social Security Act defines a shared health facility, in part, as a facility with at least one practitioner who has been paid in excess of $5,000 in any one month or in excess of $40,000 a year for services provided under the Medicare and Medicaid programs. This broadens the definition to include many group practices not of the type previously identified as abusers of federal health programs. The $5,000-per-month limit will be met by many group practices, including some that do not receive a significant amount of program payments annually. This is because many beneficiaries and physicians submit accumulated claims in mass, especially at the end of the year.

We also believe that for purposes of this bill $40,000 per year is too low and will apply to many honest practitioners in group practice arrangements who devote their practice to low income areas or treat mostly older patients.

We, therefore, recommend that the $5,000 and $40,000 parameters be changed to make the definition of "shared health facilities" focus on those types of group arrangments with demonstrated patterns of abuse in the past. We believe this change and requiring the Secretary to show "probable cause" will make identification of program abusers more cost effective.

SECTION 5

We are concerned about the proposed amendments under this section that would permit the Secretary to require PSROs to assume review of health care services outside institutional settings. We believe it is premature to give the Secretary such authority since adequate ambulatory care review mechanisms have not been developed and evaluated. Moreover, there are no agreed upon standards to determine what constitutes an appropriate and effective ambulatory review mechanism. How can the Secretary determine whether a PSRO is capable of ambulatory care review, much less require such review, when appropriate mechanisms have not yet been developed or standards defined?

For the same reasons, we think it would be an unreasonable burden on PSROs at this time to require them to develop a timetable for assuming the review of all outpatient services paid for by Medicare or Medicaid.

ASIM and several other groups are presently testing methods to assess the quality of care in the ambulatory setting. In June 1976, ASIM sponsored the first national conference on "Assessing Physician Performance in Ambulatory Care". The speakers included most of the recognized authorities on ambulatory review. Copies of the Proceedings and a special ASIM report on the conference published in *The Internist* are included with this statement. [These documents have been retained in the committee file.] We believe a review of the Proceedings will support our contention that adequate ambulatory review mechanisms have not yet been developed. Until such time as effective and acceptable methodologies can be assured, we recommend that the initiative for assuming ambulatory care review remain with individual PSROs.

SECTION 5(B)(1)

This section requires USROs to provide data and information to agencies investigating fraud and abuse. This data would be supplied upon request of such agencies or at the discretion of the PSRO, in accordance with procedures to be established by the Secretary.

We must strongly oppose this provision as presently written. It is unacceptable to allow the Secretary to prescribe the procedure for requesting PSRO information for these purposes. Instead, guidelines should be included in the law to assure that each request is reasonably justified and that confidentiality is safeguarded. Many physicians have worked hard to implement the PSRO program and to persuade other physicians that participation in PSRO is in their best interest and the best interest of their patients. Passage of a law compelling PSROs to supply data in response to any request from an investigative agency could counteract previous efforts to build physician goodwill toward the program.

We recommended this provision be deleted unless appropriate restrictions on such requests are outlined in sufficient detail to assure that they are justified and that confidentiality will be maintained.

SECTION 5(L)

This section calls for the Secretary to submit to Congress an annual report on the administration, impact, and cost of the PSRO program. Proposed Section 1171(3) of the Social Security Act would require that the report described "services determined, in accordance with the provisions of this title, to have been (A) medically unnecessary, (B) furnished in an inappropriate setting, or (C) deficient inequality."

We recommend that, in the interest of putting the deficiencies reported in the proper perspective, a new section be added requiring that the Secretary also report "serviced determined, in accordance with the provisions of this title, (A) to have been medically necessary, (B) to have been furnished in an appropriate setting, and (C) to have met standards for quality in that community."

SECTION 6

We strongly oppose this question, which would grant the Comptroller General the power to subpoena anybody for any information related to the Social Security Act. As stated previously, we believe investigative power should remain within DHEW and that the Comptroller General's office should be responsible for monitoring the performance of DHEW. The Inspector General already has broad subpoena power to investigate fraud and abuse under Medicare and Medicaid. To grant similar powers to the Comptroller General is duplicative and unnecessary. We recommend that Section 6 be deleted.

STATEMENT OF THE AMERICAN SPEECH AND HEARING ASSOCIATION

The 24,000 members of the American Speech and Hearing Association—speech pathologists and audiologists—serve the nation's more than 20 million communicatively handicapped.

The Association fully endorses H.R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, and its objective: to stem the tide of federally supported health care costs by eliminating program fraud and abuse rather than by curtailing coverage of essential services.

Because the 20 million Americans with either hearing deficits or speech impairments cannot afford any retraction in the federal government's commitment to them, this Association commends Chairmen Rostenkowski and Rogers on their efforts as reflected in H.R. 3, and the manifestation of support which the Subcommittees have lent the legislation in holding these hearings.

While this statement does not directly address the serious concerns generated by fraud and abuse in the nation's largest health care programs, it does address two points which we feel are worthy of consideration in connection with the cost-reduction objectives of H.R. 3.

One of the most pervasive cases of overutilization in the health care delivery system has been programmatic over-reliance on the physician as overseer of all aspects of health care. While this is certainly necessary and justified in the lesser skilled "aide" categories, such as paramedics and physicians' assistants, there can be no justification in the case of master's level trained, nationally certified and state licensed professionals [cf the Medicare definition of speech pathologist or audiologist, section 405.1101(t)], such as audiologists and speech pathologists.

In fact, the prevailing requirements for physician prescription and patient plan formulation for Medicare speech pathology services are the products of a legislative mishap. In 1972, Congress most appropriately extended Medicare coverage of speech pathology to those services rendered in such outpatient facilities as clinics, rehabilitation centers, and public health agencies. But, in end-of-session haste to pass the legislation which became P.L. 94–603, bill drafters analogized the provision of speech pathology to physical therapy services in Section 1861(p) of the Social Security Act. The unfortunate—and unintended—result is that the law now contains an inappropriate provision requiring that a physician prescribe a plan of treatment and re-certify the need for speech pathology services every 30 days. Not only does this requirement for federal reimbursement ignore the traditional physician-speech pathologist relationship long accepted by both professions, but it costs the communicatively handicapped, Medicare, and, ultimately, the American taxpayer countless thousands in unnecessary physicians' fees.

The Senate has already acknowledged this legislative oversight:

The provision in P.L. 92–603 unintentionally penalized the speech pathologist. By incorporating through reference certain requirements applicable to physical therapy, the provision seemed to require that there must be not only a physician's referral but also a specific physician's plan detailing the amount, duration and scope of services to be provided by the speech pathologist. Since speech pathology involves highly specialized knowledge and training, physicians generally do not go into this type of detail when referring a patient for these services. [S. Rept. 93–553, page 66, referring to H.R. 3153.]

The Senate's effort to clarify congressional intent came to naught when, with only hours remaining in the 1973 session, House-Senate conferees agreed to put H.R. 3153 aside and report a skeleton compromise bill (H.R. 11333) designed to provide an increase in social security benefits.

Requiring physician prescription and plan re-certification escalates the costs to Medicare in much the same way that Medicare requirements for hospitalization trigger a benefit period increase in costs when such care is unnecessary. Ending the physician prescription requirement for speech pathology services would address "overutilization" at a basic conceptual level.

Reform of the Medicaid-Medicare system should be just that: putting an end to programmatic weaknesses which give rise to provider abuses. The American Speech and Hearing Association can do and has done more than merely applaud federal efforts in this regard; it has one of the most active and highly effective professional ethics programs of any association. In the last ten years, the Association's Ethical Practice Board has formally handled and resolved 941 cases—the overwhelming majority of which were requests for guidance from conscientious members in interpreting the widely disseminated and enforced Code of Ethics. The Association is extremely proud that its members seek the advice of the Ethical Practice Board, since this evidences the high degree of professionalism and voluntary compliance with the Code, regarded as a model by other professions. The Association firmly believes that state licensure of health professions—where such laws establish high educational and examination standards and hold licensees accountable for ethical violations—also furthers the objective of professional responsibility.

Through complaints by its members, ASHA is becoming increasingly alarmed at institutional overcharges to Medicare for speech and hearing services provided on a part-time or intermittent basis. Institutional middlemen ar not only skimming the cream off the top but taking most of the milk, too. Under current regulations, institutional providers may bill Medicare for therapists' services provided on a part-time basis at the hourly rate that it would pay for a full-time employee, plus overhead. For part-time services less 15 hours per week, the institution may bill Medicare the reasonable going rate. The result is that Medicare is paying the same unit charge for therapy services whether or not the institution employs a therapist full time or part time. But the therapist working part time is in many cases getting only a small fraction of the amount Medicare is being billed. In one case reported to our office, a hospital billed Medicare $20 per hour, while paying the speech pathologist only $3 per hour. Thus, Medicare is paying for institutional costs unrelated to the provision of speech pathology services. While this situation could be addressed by yet another technical rule-making, the proliferations of which are themselves adding to the crippling costs of health care, there is a more direct and more effective way: allowing audiologists and speech pathologists to receive direct reimbursement for their services by recognizing those in private practice as qualified Medicare providers, commensurate with their level of training and expertise.

National Health Insurance is just around the corner. Members of these Subcommittees recognize that we must put our house in order and correct past mistakes before they are concertized into a broad federal commitment. It is essential at this time to clarify ambiguities and eliminate prevailing laxity. Toward this end, the American Speech and Hearing Association respectfully requests consideration of these proposals:

1. Clarification of section 1861(p) to eliminate the need for physician prescription and patient-plan monitoring for speech pathology services.
2. Recognition of speech pathologists and audiologists in private practice as qualified Medicare providers whose services are directly reimbursable.
3. State licensure of allied health professions as the most expeditious and constitutional means of assuring quality and accountability in the provision of health care services.

While the American Speech and Hearing Association has other concerns related to expanded coverage of speech and hearing services, we have made our comments in line with the tone these bearings have set—realism. The three propositions are technical in nature. Implementation would reduce program costs and enhance the prospect for eliminating provider abuse.

Thank you for the opportunity you have provided this Association to comment on a commendable legislative effort.

Statement of the College of American Pathologists

We are most grateful for the opportunity to present the views of the College of American Pathologists on H.R. 3, the Medicare/Medicaid Anti-Fraud and Abuse Amendments.

Ours is a non-profit, voluntary, specialty organization of physicians with headquarters in Skokie, Illinois. The College of American Pathologists was founded in 1947. Our more than 7,000 physician-members practice the medical specialty of pathology. CAP Fellows are certified by the American Board of Pathology.

Our members practice in hospitals, in independent medical laboratories, in medical schools, in military institutions, and in various facilities of the Federal, state, and local governments. In addition, our members work in medical laboratory research institutions and in industries producing medical devices and in-vitro diagnostic products.

The CAP already has taken a position in support of the principle of anti-fraud and abuse legislation. Last year when such legislation was introduced in the Senate by Herman E. Talmadge and in the House by Representatives Paul Rogers and Dan Rostenkowski, the College sent a telegram to these legislators supporting the legislation. In that telegram, the College said: "As we have stated in hearings before the Senate Health Subcommittee and in correspondence with Senator Frank E. Moss, the College abhors fraudulent practices and believes that lawbreakers should be punished to the full extent of the law." Our position is the same today as it was last year.

Mr. Chairman, your intent to improve federally financed health programs and to rid these programs of unscrupulous individuals, physicians and non-physicians alike, is shared by the College. We do have concerns, however, regarding certain portions of the bill.

These concerns are based upon the knowledge that a large majority of physicians are honest and dedicated providers of quality health care. As Congressman Rogers remarked in his introductory speech on H.R. 3, "Fraud and abuse in our medical care program benefit no one—except the unscrupulous provider. The honest, hardworking provider suffers, because his reputation is damaged. Indeed, we seem often to have reached the unfortunate situation where simply because providers receive significant amounts of reimbursement through our public medical care programs, they become suspect."

We are concerned that some of these honest, hardworking providers may be harmed unless protective measures are built into any legislation which addresses fraud and abuse.

Additionally, H.R. 3 contains several provisions which would amend the Social Security Act to increase the scope of PSRO review at a quicker pace than present law provides. We welcome the opportunity to work through PSRO organizations to combat fraud and abuse. However, let us not weigh down these organizations with responsibilities for which they are not prepared.

As the professional organization representing the majority of physician-directors of laboratories in the United States, we are compelled to respond briefly to some of the charges that have been leveled against clinical laboratories in the past few years. There have been headlines in newspapers, Senate and House Committee reports and speeches on the floor of both houses that refer to rampant fraud and abuse in the clinical laboratory, criminal elements invading the industry and kickbacks to private physicians.

We are aware that there have been instances where clinical laboratories have engaged in illegal activities. However, we question whether fraud and abuse are rampant in clinical laboratories and that kickbacks and rebates are common practice. If one reads closely enough, most of the reports of these activities involve a limited number of clinical laboratories which in almost every case are owned and/or operated by a profit-minded non-physician. This method of operation by unethical, unprincipled persons has been seen time and time again in Federal and/or state funded programs. We abhor these practices as intensely as do the members of legislative committees and the public. By association they have placed a black mark on pathologists as well as all who work in the laboratory field. This practice must be stopped and the perpetrators subjected to the penalties provided by law.

We, as an organization, are taking actions against members who may participate in illegal activities. The CAP Board of Governors has provided for disciplinary procedures if a member is convicted of or admits to a crime. Further, we believe it is to our credit that we have attempted several times to obtain the names of any physicians who may have been involved in the clinical laboratory "scandals" uncovered by Senator Moss's Subcommittee on Long Term Care of the Senate Select Committee on Aging. To date, we have received no response.

We would now like to comment on specific sections of the bill.

In our view, Section 3, Disclosure of Ownership and Financial Information, implies that virutally every health care facility and practitioner, would be required to comply with the stated provisions. The administrative burden that disclosure would place not only on the government, but also on providers and suppliers, would undoubtedly be enormous. The provision that providers and suppliers who do not furnish a "significant volume" of services would be exempt from disclosure, is far too vague a safeguard. It appears to us that Section 3 is based on the assumption that fraud and abuse commonly exist in every facet of health care except for the solo practitioner. To implement this assumption into law would render the program ineffective.

The CAP recommends that Section 3 of H.R. 3 be amended to indicate that disclosure of ownership and financial information is required only of suppliers and providers who are associated with "shared health facilities" or "medicaid mills".

Under Section 3, subpart (a)(1)(F), access to books and records pertaining to billing and payments for goods and services would be mandated for certain entities, including independent laboratories. We strongly recommend that this subsection be clarified, particularly the meaning of "reasonable access" and the safeguards that are provided to protect that confidentiality of medical records.

We now would like to turn our attention to the creation of a new Section 1125 of the Social Security Act, entitled "Shared Health Facility." It is our opinion that the definition of shared health facility is much too broad since it encompasses virtually all health care practitioners who are not in solo practice, associated with a hospital or HMO, or working for the government.

As we have stated earlier, the "rip-off" of the government and the public is unfortunately nothing new in governmentally supported programs. In fact, the College would not be surprised if some of the persons involved in fraud against the Medicare and Medicaid programs were at a previous time involved in other instances of a similar nature. These are highly adaptable individuals. For this reason, it seems most plausible to us that a person engaged in fraud or abuse of government health programs would change his modus operandi once a definition of shared health facility has been established to elude the mesh of the net.

Section (3)(B) of the definition of shared helath faciilty would harm the honest practitioners and create a loophole for the very groups the Section purports to expose.

Under this definition, two or more health practitioners falling under the provision of Section (3)(A) could each submit billings for less than $5,000 in any one month or an aggregate of $40,000 in the preceding twelve months and escape the intent of the legislation. The honest practitioner who is legitimately billing for more than $5,000 each month, on the other hand, would be subject to investigation.

Medicare and Medicaid carriers and intermediaries and PSRO's already have designed computerized and manual review systems. When a questionable billing is processed, it is identified for further review. Additionally, the investigations by Senate and House Committees, Federal, state and local governments, and private organizations have discovered the characteristics of situations in which fraud and abuse are likely to occur, including "medicaid mills." Moreover, law enforcement agencies have been very successful in developing "profiles" of persons who are likely to commit a particular crime in a particular set of circumstances, e.g., an airline hijacker.

In place of a detailed definition of a shared health facility or medicaid mill, we would suggest the following:

The development of a computerized or manual system that would include mechanisms similar to those used by carriers and PSRO's to identify suspected instances of fraud or abuse. Built into that system would be modifiable characteristics of shared health facilities or medicaid mills which would take into account the changing operations of those who would commit fraud or abuse the system. Additionally, a profile of persons who may engage in fraud or abuse should be developed. It would be hoped that the system would be organized in cooperation with medical associations and other experts.

The CAP must question Section 6 of H.R. 3, which gives the Comptroller General the power to issue subpoenas. P.L. 94–505 established the Office of Inspector General in the Department of Health, Education, and Welfare. This office, granted the power of subpoena, will serve as the central point in the investigation of fraud and abuse of government financed health care programs. To distribute further the power of subpoena would serve only to weaken the Office of Inspector General by removing its strength—a centralized operation. It seems appropriate and desirable for the Comptroller General to cooperate with the Inspector General with regard to investigations involving government financed health programs.

We now would like to make several short statments on the PSRO amendments contained in Section 5 of H.R. 3.

First, we have some concerns that the amendments to Section 1155 of the Social Security Act may possibly overburden a number of PSRO's that are still in an early developmental stage. The Secretary should not grant a PSRO the responsibility to review ambulatory care unless the Secretary is assured that the PSRO has the capability to do so and only after the PSRO has initiated such a request. PSRO's should remain primarily educational and medical, not regulatory and punitive.

Second, the sections of H.R. 3 which would amend Section 1166 of the Social Security Act should be reviewed to ensure that adequate safeguards are in place to retain the confidentiality of PSRO records as provided under current law.

We would now like to mention an issue that is pertinent to the discussion of H.R. 3—the issue of disclosure billing. We support the implementation of existing regulations and suggest that intermediaries/carriers be instructed to require physicians who have laboratory services performed outside of their offices to identify the laboratory providing the services and the amount charged to or paid for by the physician. The CAP has repeatedly maintained that the proper implementation of existing regulations could significantly reduce Medicare laboratory expenditures and prevent what has been alleged to be abuse of the Medicare and Medicaid programs. We have attached a copy of the carrier/intermediary instructions which are applicable to the issue of disclosure billing (Medicare Carriers Manual, Part 3, Sections 4011.3 and 4110.2).

Mr. Chairman, the College believes law-breakers should be punished to the full extent of the law. We would expect that the honest individual providing services within the law would be protected from harassment and excessive regulatory controls.

At its annual meeting in Dallas in June of last year, the American Medical Association adopted the following statement:

"The American Medical Association condemns and deplores all acts of fraud and wrongdoing, including in particular any wrongful acts as recently reported in the Medicare and Medicaid programs. We urge that responsible government agencies proceed with all due speed in the prosecution of all who are guilty of fraudulent misconduct. We will continue to offer our cooperation and assistance in bringing to an end such activities."

The College of American Pathologists endorses this statement wholeheartedly and adds its own pledge to cooperate and assist in any way possible so that acts of fraud committed in violation of the law and the Medicare and Medicaid regulations can be stopped and the violators punished.

On behalf of our members, we appreciate this opportunity to present the views and the position of the College of American Pathologists on this very significant and important legislation.

Medicare Carriers Manual

Part 3
Claims Process

U.S. Department of
Health, Education, and Welfare
Social Security Administration
HIM 14-3 (7-66)
Reprint Date (5-76)

Where the combined charge for inclusive dates is not consistent with the reasonable charge for the individual service, the carrier should obtain more detailed information to resolve the discrepancy. See § 4145 for "flat fee" or "package charge" billing.

Example: The bill is for 5 office visits and the charge is $30. The physician's customary charge for office visits is $5, and the carrier's records do not contain separate customary charges for initial and subsequent office visits. In this case, the carrier would need to determine the reason for the higher charge, e.g., contact with the physician might reveal that $10 was charged for the initial visit when the patient was given a complete examination.

Compare the dates of service with the Part B entitlement date and termination date, if appropriate, furnished by SSA to eliminate services furnished before the first month of entitlement and after termination. Also, check against the carrier file for possible duplication of claims.

Services for which payment is being requested should occur on or after the date the individual's coverage became effective. In addition, although the individual's coverage may have been terminated, payment may nevertheless be made for any covered services received during his coverage period prior to termination. (However, see § 7250 for collection of premium arrears from benefits payable to an enrollee.) (See § 2005.1 concerning the date of incurred expenses for surgical and obstetrical services.)

For provisions applicable to the time limitation on filing claims see §§ 3004, and 3045.1E and § 4015.

4011.3 __Item 7B: Place of Service__.--The place of service must be indicated in this item showing the appropriate code from the footnote at the bottom of the form. When the code OL is used, the place of service must be described in item 7C or item 13.

When physician services are rendered in a nursing home that contains a certified skilled nursing facility as a distinct part, the place of these services must be accurately recorded in this item. The nursing home code may only be used to designate services furnished in the noncertified parts, while the skilled nursing facility code must be used for services furnished in the certified portion of the facility.

In the case of hospital visits by physicians, it may be presumed, in the absence of evidence to the contrary, that visits billed for were made. Thus, verification of each claim need not be undertaken before payment is made. However, spotchecks of available records with respect to a particular physician should be made when the carrier's records show questionable patterns of utilization. Confirmation should also be obtained where the medical facts do not support the frequency of physicians' visits or in cases of beneficiary complaints.

If there is a question whether the visit had been made, the burden of proof is on the physician to substantiate the occurrence of a hospital visit. Verification should be made primarily on the basis of the physician's own entry in the patient's record at the hospital. Entries in the hospital record made by other persons could also be used to substantiate a hospital visit. For example, an entry in the nurses' notes indicating that the physician saw the patient on a given day would be acceptable documentation. A statement by the beneficiary would also be acceptable documentation provided it was made sufficiently close to the alleged date of the visit that it would be reasonable to give it probative value. Entries in the physician's own records represent possible secondary evidence. However, these are of far less probative value since they are self-serving statements and judgment would have to be exercised regarding their authenticity. For instance, do all the entries appear to have been made at the same time? The fact that the hospital's policy requires daily physician visits would not be conclusive evidence if, in the individual case, the facts did not support a finding that daily visits were actually made.

In many cases, the copy of the hospital or SNF billing form, which is forwarded to the carrier when a provider claim is submitted to the intermediary, will be available and will provide supplementary information needed to pay for Part B services.

If the services of an independent laboratory are indicated, the name of the facility where the tests were performed must be entered in item 13. Where changes for the services of a portable X-ray supplier are included in a physician's charge, the portable X-ray supplier should be identified in item 7C.

A claim may be processed even though the place of service is not shown if it can be inferred from other information in the claim or it is not material to the claim.

4110.2 Laboratory Services by Physicians.--When an attending physician providing services in an office setting includes in his bill services obtained from a laboratory outside of his office, the laboratory where the services were obtained must be identified in item 13 and "IL" placed in item 7B. If the physician performs the laboratory service in his own office, an "O" is placed in item 7B.

A physician attending a hospital inpatient who includes charges for laboratory services on his bill must identify the laboratory from which he obtained the services. If the services were rendered by a physician in the capacity of a qualified hospital's radiologist or pathologist, it must be so indicated. This information is necessary so that the carrier can apply the 100 percent reimbursement rate (see § 2020.9). Services obtained from an independent laboratory or performed by a physician other than a physician in the fields of radiology or pathology in a qualified hospital are subject to the Part B deductible and coinsurance provisions. (No deductible and coinsurance will be applied in the case of negotiated rates for laboratory services. See §§ 5120ff.)

If the claim or bill does not show the source of laboratory service, i.e., an "O" in item 7B or "IL" in item 7B with the name of the laboratory in item 13, the carrier must determine where the services were performed. To aid in processing physicians' bills for laboratory services, carriers may find it useful to develop and maintain a current file showing the tests particular physicians in the area customarily perform in their own laboratories in diagnosing and treating their patients, or establish a similar method for determining a physician's source of laboratory services. When a physician's bill raises a question about the source of the laboratory tests which the carrier cannot resolve from information in its file, the name of the laboratory must be requested from the physician. If the laboratory is located outside the carrier's service area, the carrier requests information from the RO about the specialty certification for the test(s) being billed. (See § 4110.3 regarding the specialty provision.)

When a claim for physician's services includes service by an unapproved independent laboratory, payment for the laboratory services must be denied. However, the physician's customary office visit charge, which ordinarily includes his evaluation of the test results, should not be reduced because the program will not pay for the test he obtained from an unapproved laboratory.

4110.3 Independent Laboratory Services.--The quarterly lists furnished to carriers by SSA (see § 2070.1D) identify all approved independent labs within the carrier's service area and specify the approved specialties and subspecialties for each lab. Bills for laboratory services must be compared with the lists of approved labs and their certified tests and procedures. Carriers can clerically review these bills, or program a

STATEMENT OF THE COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES NATIONAL LEAGUE FOR NURSING

The Council of Home Health Agencies and Community Health Services, national spokesman for 1500 Medicare-certified home health agencies, appreciates the opportunity to submit this statement on H.R. 3, Medicare-Medicaid Anti-Fraud and Abuse Amendments.

CHHA/CHS is concerned that the allegations of fraud and abuse within federally supported health programs have served as barriers to the expansion of services provided under these programs. We commend you for moving one step closer to removing these barriers by trying to enact fair and effective legislation to monitor fraud and abuse. We support the intent of H.R. 3 and recommend it be expanded to cover Title XX.

We believe that the great majority of home health agencies are providing quality services. We recognize, however, that many home health agencies may be guilty of "benign neglect," that is, operating at less than maximum efficiency. To this end, we are expanding and making explicit the business and financial management criteria in the NLN/APHA Program for Accreditation of Home Health Agencies and Community Nursing Services. We also require accredited agencies to have a policy on conflict of interest and disclosure. Further, CHHA/CHS staff resources are being expanded in the area of business practice by upgrading present staff expertise and adding an additional consultant with specific expertise in business and financial management. In this manner we can provide the input agencies need to achieve sound, efficient administrative practices that are essential to the delivery of cost-effective quality care.

Agencies, also, are becoming more aware of this need, as evidenced by the increasing number of fiscal managers being employed. In agencies with good fiscal control, a balance must be struck mixing the professional services with optimum productivity ratios which are so appropriate in product industries.

We do not deny that some bad apples exist and we, with you, want to rid the home health field of them. CHHA/CHS is interested in establishing fiscal and utilization rate indicators which will alert monitoring bodies to the possibility of fraud and/or abuse. Monies must be allocated to the Social Security Administration specifically earmarked to develop program capacity to extract utilization and length of stay data under the Medicare program. The Social Security Administration should make these data available to the community and the health systems agencies.

Certificate of need, while not a panacea, is a beginning. Although certificate of need by itself cannot assure that quality services will be delivered in a cost effective and efficient manner, it can prevent the proliferation of agencies which may or may not be delivering quality services. We are very concerned that the recently promulgated regulations under the Health Planning Act exclude home health agencies from certificate of need. That legislation needs to be amended to specifically include home health agencies.

We also believe the industry must monitor itself and we intend to do this by working very closely with government and fiscal intermediaries. Initiation of dialogue at SSA's Division of Contractor Operations conferences would be a step in the right direction toward blending the public and private resouces for monitoring the industry.

We do not believe that PSROs should have the responsibility for monitoring the provisions of this act. We oppose this on the basis that PSRO review should be limited to quality assurance determinations. We believe that financial and ownership review is better kept separate since differing expertise is required. We recommend that responsibility for financial and ownership review be vested with the Inspector General of HEW.

Once again, we commend you for your efforts and we stand ready to help you in any way we can.

NOTE: Attachments—workshop flyers, Personnel Management and Fiscal Management, retained in Committee files.

Delmarva Foundation for Medical Care, Inc.,
Easton, Md., March 1, 1977.

Hon. Daniel Rostenkowski,
Chairman, Ways and Means Health Subcommittee,
U.S. House of Representatives, Washington, D.C.

Dear Congressman Rostenkowski: We would like to personally convey to you the enclosed letter from the Executive Director of our Foundation. We have both been actively involved in the PSRO program since its inception and feel that Mr. Borchardt has accurately summarized the Foundation's position and the feelings of our member physicians on the Eastern Shore of Maryland. The ability of PSROs to become involved in solving the problems of long term care delivery should not be diluted by giving the Secretary of HEW the legal power to impede PSRO authority in long term care facilities.

We hope you will carefully consider the potentially adverse consequences for the nation if the PSRO program becomes increasingly locked into ineffective, administrative procedures without the flexibility to use physician expertise in areas with potential impact. The law, as orignally enacted by Congress, emphasizes peer review by local practicing physicians. To further limit the permitted role of physicians in required peer review activities is a backward step.

Sincerely yours,

J. H. Cutchin, Jr., M.D.,
President.
R. Lane Wroth, M.D.,
Chairman, Long Term Care Subcommittee.

Delmarva Foundation for Medical Care, Inc.,
Easton, Md., March 1,1977.

Hon. Daniel Rostenkowski,
Chairman, Ways and Means Health Subcommittee,
U.S. House of Representatives, Washington, D.C.

Dear Congressman Rostenkowski: We understand that you will soon be holding hearings on HR 3 to consider (along with Medicare and Medicaid antifraud measures) the Professional Standards Review Organization (PSRO) program and possible amendments to the law. Our organization was designated a PSRO in 1974, has fully implemented a hospital review system, and has been conducting review in long term care (LTC) facilities for more than nine months. On the basis of our experience we would like to convey our views and a strong recommendation that Congress continue to stress that HEW should begin to use PSROs in implementing utilization and quality review in long term care facilities.

Our particular concern is with provisions which would effectively give the Secretary of HEW more discretion in deciding the extent of PSRO involvement in long term care facilities. We are aware that the effectiveness of PSRO utilization review in short-term hospitals is being questioned. We share many of those concerns and are paring our hospital review program to eliminate those review activities which have no demonstrable effect on utilization or quality of care. Our reduction in acute activity has been timed to correspond with the implementation of long term care review, so that additional funding has been unnecessary. Fortunately, our involvement in long term care started before HEW began to constrain this legally required PSRO activity.

Our experience in long term care has been rewarding. Representatives of other PSROs who have begun LTC review concur that local practicing physicians are in a unique position to have a favorable impact on the provision of long term care. As they become familiar with the long term care system, PSRO physicians quickly begin to share the views expressed by Federal and local governments concerning the recognized problems of this aspect of health care delivery. Once the organized commitment of physicians is secured, they are uniquely capable of instituting changes which are beyond the capability of any governmental enforcement mechanism.

Since implementation, we have seen remarkable efforts by LTC facilities to eliminate any problems which our physicians and staff identify. Ability to match Medicare or Medicaid patients with the needed type of facility is remarkably enhanced by the link between LTC admission review and continued stay review in hospitals. Paperwork imposed on facilities to meet State utilization review and control requirements has been reduced, with the potential for greater streamlining once authority to set review requirements is transferred officially to PSRO. Our greatest contribution has been to renew the interest of practicing physicians in problems that had long been of only peripheral concern to them. The program has been able to establish a continuing, outside, objective presence in facilities. Our physicians are continually analyzing our activities to make them more effective in solving the problems they see through the PSRO program. There is great potential for even more significant advances as government realizes that it has a vehicle which continually assures that Federally-financed care is actually rendered, is necessary and appropriate, and is best provided within a particular setting. With this certification, the basis exists for a wide range of new government reimbursement options to create incentives for economical use of all long term care alternatives, including non-institutional care.

The strongest argument for requiring HEW to implement the PSRO law as it now exists is the amazing ineffectiveness of the non-PSRO requirements for utilization review and control which Congress has been pressuring HEW and the states to implement. In Maryland, this system's primary emphasis is on proper forms completion, with no assurance of proper review and actions. Those we have talked to locally feel that the State review requirements are unproductive and, in many cases, have actually been detrimental to proper care.

The cost of maintaining this "system" of review can be conservatively estimated at more than $100 per patient per year in direct costs incurred below the State level alone. This estimate includes only the costs of preadmission review, reimbursed time of physicians at monthly review meetings, and the cost of annual medical reviews. Excluded is the indirect cost of nursing home staff time diverted to meetings and paperwork. The PSRO program is providing more frequent review by outside professional reviewers working with physician advisors for a present cost of less than $50 per patient per year. Although our program meets and exceeds the State requirements, it remains essentially a voluntary and duplicative effort while HEW (through the Social and Rehabilitative Service) refuses to begin any transfer of responsibility to the PSROs, as clearly specified in PL 92–603.

The State of Maryland wants responsibility shifted to the PSRO mechanism, but has been kept from doing so while the relative merits of PSRO long term care review are debated at the Federal level. As this debate continues, the fact remains that the law requires a transfer to PSRO authority, but PSROs can only implement LTC programs which "fit" or duplicate State requirements. Even doing this, HEW does not recognize PSRO review decisions or require facilities to accept them. The Secretary of HEW is authorized by law to waive these duplicative requirements as PSRO is implemented. The fact is that two systems of review are competing for funding within HEW. State systems are in the process of building staff with little attention to assuring a system "compatible with PSRO review" as the currently applicable regulations intend. Needless to say those who must try to meet these laws locally are thoroughly confused.

The answer to the confusion, we feel is not to give HEW a legal excuse to pick and choose review programs within the Department in accordance with shifting political pressures. Congress should require adherence to the intent of the PSRO law which was meant to give local physicians their "last change" to demonstrate an ability to conduct effective peer review. Your amendment effectively delays, and perhaps eliminates, giving physicians that chance.

Sincerely,

PETER J. BORCHARDT,
Executive Director.

National Medical Association, Inc.,
Washington, D.C., March 4, 1977.

Hon. Dan Rostenkowski,
Chairman, Subcommittee on Health,
Committee on Ways and Means,
Longworth House Office Building,
Washington, D.C.

Dear Congressman Rostenkowski: Please find enclosed a statement on H.R. 3 developed by the Coalition of Health Advocates of Washington, D.C. Your sincere attention to the contents of this statement would be greatly appreciated.

The Coalition is extremely interested in legislaion regarding health care and the interdisciplinary nature of the group assures evaluation that is broad-based. We would like to be kept informed of any issues relating to the area of health.

Thank you in advance for your cooperation in this matter.

Respectfully,

Alyce C. Gullattee, M.D.,
First Vice President,
Member, Executive Committee,
D.C. Coalition of Health Advocates.

Enclosure.

Position Paper on H.R. 3 of the 95th Congress by the D.C. Coalition of Health Advocates, Presented by Alyce C. Gullattee, M.D.

The Coalition of Health Advocates of the District of Columbia is a private, non-profit group of individuals and organizations concerned about health care. The membership is composed of over 50 health care providers and consumers representing organizations having over 1,000 members. Our organization has reviewed HR–3 of the 95th Congress, "Medicare-Medicaid Anti-Fraud and Abuse Amendments," and has prepared the following statement.

We fully appreciate and agree with the purpose of this Bill "to strengthen the capacity of the Government to detect, prosecute and punish fraudulent activities under the Medicare and Medicaid programs and for other purposes." Theer are aspects of the bill, however, which seem to carry the potential for creating serious problems. This is particularly true of the Amendments related to PSRO organizations and the definition of Shared Health Facilities.

The Amendments of the Social Security Act related to PSRO Organization Section 5a, Section 1166 subsection (a) (page 23, lines 5–17) directs PSRO to provide data and information upon demand to Federal and state agencies or at the discretion of the PSROs. Our objections to this arrangement are as follows:

1. This section gives the PSRO organizations a regulatory "police like" function which is contrary to its primary goals of evaluation of quality care and cost reduction. Moreover, this additional regulatory activity is likely to interfere with their abilities to carry out their primary function. The provision of information by PSROs to combat fraud, etc., on request and particularly the necessity for initiating such information undoubtedly will violate confidentiality of privileged doctor-patient relationships and impair the cooperation which most physicians are now giving the PSRO organizations.
2. The determination of fraudulent and abusive practices of non-physician health care providers by the physicians—only PSRO organizations is grossly unfair to the dentists, nurses, and allied health professionals who supply services.
3. The present PSRO organizations, in most jurisdictions, have inadequate numbers of Blacks and other minorities in decision making roles. This, in our view, severely impairs the abilities of these organizations to evaluate social, cultural and economic aspects of medical care which may be responsible for apparent instances of fraud or abuse.

The definition of "Shared Health Facility" Sec. 1125 subsection 1, 2, and 3 (pages 12-13, lines 6-16) is very broad and includes virtually every type of cooperative arrangement between health care practitioners. We feel that the restrictions and regulations imposed on a Shared Health Facility will undoubtedly cause many to either:

1. Refuse to accept assignment for Title 18 and 19 patients (which occurs now with increasing frequency and results in the patient having to either pay for his care or seek another practitioner), or

2. Refuse to enter such cooperative arrangements despite the fact that such arrangements have been shown to be a more effective technique of health care delivery.

This "too broad" interpretation will also cause an inordinate increase in the "paper-work" required of those practitioners in such arrangements. Further, it is unlikely that these measures will be effective in the prevention of fraud and abuse.

For these reasons, the Coalition strongly recommends re-evaluation of these two components of HR–3. The PSRO Amendments should, at the very least, not require initiation of investigation into fraudulent activities by the PSROs and further should not require collection of additional data designed solely for regulatory activities. The definition of Shared Health Facility should only include single specialty groups and practitioners in all other types of arrangements should be handled as solo practitioners.

We appreciate the opportunity of presenting our views on this Bill.

STATEMENT OF MICHAEL D. BROMBERG, DIRECTOR, NATIONAL OFFICES, FEDERATION OF AMERICAN HOSPITALS

I would like to present for your consideration and for inclusion in the record of the joint Subcommittee hearings, the views of the Federation of American Hospitals on H.R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments Act. The Federation represents the interests of over 1,000 investor-owned hospitals across the country.

On several occasions in the past, most notably in testimony presented in connection with H.R. 15390, the anti-fraud and abuse measure introduced by Chairman Rogers last year as well as S.3205, Senator Talmadge's Medicare reform measure, we have expressed our support of continued attempts to eliminate fraud and abuse in these government sponsored programs. The investigation and punishment of those institutions labeled "Medicaid mills," for example, are necessary to protect the public at large, as well as the integrity of the overwhelming majority of honest and dedicated providers of health care services.

After reviewing H.R. 3, we are pleased to endorse the legislation and to urge prompt Congressional approval. It appears that this legislation, revised since last year's introduction of anti-fraud measures, takes into account and resolves several problems that would have confronted hospitals had the original version of the legislation been enacted. H.R. 3 permits hospitals to cooperate fully in the effort to eradicate fraud and abuse in Medicare and Medicaid without, at the same time, imposing administrative hardships on the institutions and/or the physicians who service their patients.

Specifically we are pleased to see that the bill clarifies the prohibition on factoring of claims, permitting hospitals to act as billing agents for physicians practicing in connection with the facilities. Last year's legislation, which appeared to ban such collection procedures, would have greatly disrupted the routine billing practice which hospitals offer as a convenient service for physicians with hospital privileges as well as those physicians directly employed by the facilities. Since the billing is being handled efficiently already, it would make no sense placing this added responsibility with the physicians whose time can be better utilized.

Another modification which meets with our approval is the deletion of the requirement in the earlier version that information relating to an institution's costs and charges be in the form of a "consolidated certified cost report." Although we realize that the disclosure section is of prime importance, last year's proposed legislation would have imposed a hardship on hospitals. There is no cost justification for a requirement that either an outside certified public accountant, or one employed by the hospital, perform the certification. We believe that it is sufficient that the administrator simply sign the report indicating that the information as reported is true to the best of his knowledge. We would recommend, however, that the bill be amended to state that the entire disclosure section only be applied in those cases where fraud and/or abuse are suspected in order to prevent "fishing expeditions."

We support the provision contained in Section five of the bill which would permit physicians who do not have a "significant financial interest" to perform PSRO review of those services for which they are not directly responsible. At the present time, the law states that physicians with "any" financial interest in an institution are precluded from performing such review. Since many of these individuals own only a very small amount of stock in a hospital or in a multi-faciilty corporation owning numbers of hospitals, the proposed amendment deals more realistically with any potential conflict of interest. In addition, such a change would remove the hardship currently placed on rural areas where the supply of physicians to serve on peer review panels is already limited, by permitting those individuals with a minimal financial interest to participate in the review process. This change would also bring the qualifications for peer review in line with those currently existing for Medicaid utilization review, as provided by the passage of P. L. 94–182. Although the Senate version of the fraud and abuse bill does not contain PSRO amendments, it is our hope that similar language will be added by that body when that bill is marked-up.

Once again the Federation of American Hospitals would like to extend its support of this vital legislation and we applaud your efforts to crack down on the manipulation of government supported patients and the misuse of government fraud by those physicians and institutions engaged in Medicare-Medicaid fraud and abuse. The overwhelming proportion of health care providers are performing admirable jobs in meeting the health needs of the public. It is in our interest as well as yours to see that the malfeasants are caught and prosecuted. Therefore, it is our hope that this bill, with the few suggested amendments, meets with quick Congressional approval as well as prompt Presidential action.

FEDERATION OF AMERICAN HOSPITALS,
Washington, D.C., March 2, 1977.

MR. JOHN MARTIN,
Chief Counsel, Committee on Ways and Means,
Longworth House Office Building, Washington, D.C.

DEAR MR. MARTIN: It is our understanding that the subject of uniform accounting systems may be discussed as part of the joint hearings on H.R. 3, as a result of legislation, H.R. 4211, cosponsored by Congressman Paul Rogers and John Moss. H.R. 4211 calls for the development of a uniform functional accounting and statistical system to be used by hospitals.

The Federation of American Hospitals, which represents the interests of investor-owned hospitals, is concerned about the fairness and cost of imposing such a system on all hospitals, varying as they do in scope of services, size, and sophistication in accounting departments. We believe that a uniform reporting system can be developed that will accomplish the same in terms of data collection without imposing the added expense and duplication of accounting records that the proposed uniform accounting system would entail.

It is our understanding that Congressional testimony will be presented in support of this proposal as part of your hearings on the Medicare-Medicaid Fraud and Abuse legislation. Unfortunately, other interested parties have not had time to prepare comments on the new uniform accounting amendment. We would hope that in the interest of fairness and opportunity for public comment, you will postpone consideration of this complex issue.

We respectfully ask that this communication be made a part of the hearing record on H.R. 3 as additional comments by the Federation of American Hospitals.

Sincerely,

MICHAEL D. BROMBERG,
Director, National Offices.

Health and Hospital Services,
Bellevue, Wash., March 7, 1977.

Hon. Al Ullman,
House of Representatives,
Longworth Building,
Washington, D.C.

Dear Representative Ullman: We understand a bill, HR 4211, has been introduced by Representatives Moss and Rogers, which would mandate a uniform functional accounting system for hospitals as proposed by the Social Security Administration under its development plan for P.L. 93-641, Section 1533(d).

Please do not support this bill. The system proposed is rigid and administratively complex. Hospitals wishing to continue providing management with adequate financial data would be forced to maintain two separate systems. The proposed system states that "a hospital will not be granted an exception to the establishment of an account solely because of accounting difficulty." This accounting system would be particularly burdensome to the small hospitals.

Uniform accounting guidelines, as well as uniformity of reporting, are both desirable and feasible. But many alternatives are available, some of which are already in use. Flexibility is essential to the success of a system which must provide management with essential information as well as furnish data on a uniform basis to governmental agencies and other interested parties.

The hospitals which we own and operate: Ketchikan General Hospital, Ketchikan, Alaska; St. Joseph Hospital, Bellingham, Washington; St. John's Hospital, Longview, Washington; and Sacred Heart General Hospital, Eugene, Oregon will be adversely affected by this legislation, and increased costs will assuredly result. We urge your stand in opposition to the proposal.

Sincerely,

J. T. Whitman,
Senior Financial Officer.

Statement of R. R. Kovener, Associate Executive Director, Hospital Financial Management Association

The Hospital Financial Management Association is a professional membership organization representing more than 15,000 individuals who hold financial management positions in hospitals and allied health care institutions or who are directly involved in organizations related to health care financial management. These are the individuals who will be responsible for implementing this legislation if enacted.

H.R. 4211 is addressed to a number of issues which are critical to the health care industry's ability to provide health services to the public. We believe a uniform functional accounting system will not ensure the achievement of the objectives to which this legislation is directed and would be counter-productive. The cost of implementing a uniform functional accounting system and the interference with management's ability to meet its responsibility for managing the hospital could have drastic implications. It is a mistake to assume that requiring uniform functional accounting will provide the solution to the problems of health care cost increases, equity under current payment formulas, the development of alternative payment mechanisms or control of fraud and abuse. Accounting systems which provide the flexibility needed to meet hospital management's information needs can also meet the legitimate information needs of government and non-government third party payers. Reporting of financial information for a variety of defined purposes to organizations external to health institutions is appropriate. If the information is properly interpreted it will provide meaningful and comparable data.

While we appreciate the need for accurate and comparable data which would facilitate health policy decision making, we do not agree that mandating a uniform functional accounting system is a prerequisite for attaining this goal. For the following reasons we urge that H.R. 4211 not be enacted:

1. Hospital management's information needs are primary, not secondary to the information required for external reporting purposes. Management's needs are best met by responsibility accounting which requires flexibility. Responsibility accounting is essential for management fulfillment of its responsibility for the efficient and effective operation of the institution.

2. External requirements for uniform information can be met by developing uniform reports with uniform definitions. If uniform definitions are developed, an accounting system can provide the data needed for the specific purpose of the report.

3. Without sufficient specificity any system will be needlessly costly. The information required for management and for external reporting purposes must be clearly defined before an accounting system is developed to meet these defined reporting needs. To prescribe an accounting system that will encompass all possible reporting requirements before those requirements are clearly defined is bound to result in wasted time and effort.

4. A uniform accounting system should not be mandated without a thorough analysis and weighing of the benefits of uniform accounting as opposed to its adverse consequences.

HFMA's Principles and Practices Board has done an indepth study of uniform accounting and reporting. The results of this study will be available in a few weeks. A copy will be provided as soon as it is available.

DEFINITIONS

This bill calls for a uniform functional accounting and statistical system. The only term in A Discursive Dictionary of Health Care similar to those used in this bill is "uniform cost accounting." To avoid any possible confusion in the definition of terms, the following definitions have been used as a basis of comments in this statement.

The preferred definition for the word "uniform" in Webster's New Collegiate Dictionary, copyright 1975 by G&C Merriam Company is, "having always the same form, manner, or degree; not varying or variable."

The term "accounting" is defined in the same source as "a system of recording and summarizing business and financial transactions in books and analyzing, verifying and reporting the results."

"Functional" is defined in the AHA Chart of Accounts for Hospitals as, "... the reporting of financial information according to type of activity." Webster's defines "statistics" as a "collection of quantitative data."

As is explained in the AHA Chart of Accounts for Hospitals, "functional" information is different from that required for management. It notes that "responsibility reporting is necessary for evaluations of and by hospital management." Accordingly, management needs are excluded if accounting is exclusively functional. Since the word uniform excludes any variation; the term uniform functional accounting by definition excludes all consideration of management information needs. If this is not what is intended either different terms should be used or the terms used should be defined.

The word "reporting" is encompassed within the definition of "accounting." We believe that, with proper definition, "uniform functional reporting" can be achieved.

Therefore, a "uniform functional accounting system" is an unvarying set of principles relating to the systematic organization, authentication, recording, classifying, processing, summarizing, analyzing, interpreting and supplying of dependable and significant information covering transactions and events organized according to type of activity which are in part at least of a financial character. It is applicable to a regularly interacting or interdependent group of items forming a unified whole.

MANAGEMENT'S INFORMATION NEEDS ARE PRIMARY

The accounting system of a hospital must satisfy the requirements of internal management of the institution, external entities, such as the accounting profession, and governmental and non-governmental organizations which pay for hospital services on behalf of certain classes of patients.

The most important of these requirements are those of internal management. According to Accounting Research Study No. 7, published by the American Institute of Certified Public Accountants, "Accounting is the body of knowledge and functions concerned with systematic originating, authenticating, recording, classifying, processing, summarizing, analyzing, interpreting and supplying of dependable information covering transactions which are, in part at least, of a financial character (and) required *for the management and operation of an* *entity and for the reports that have to be submitted thereon to meet fiduciary and other responsibilities.*" (Italics added.)

Internal management and the hospital's board of directors are ultimately responsible for the management of the hospital. Management needs financial information on a periodic (monthly or more often) basis during the accounting year so that it can evaluate the effectiveness of those who are responsible for controlling the costs necessary to provide hospital services and take corrective, timely action as necessary. In order to accomplish this objective, management must have access to financial information summarized to correspond with the areas of responsibility which has been defined by management. Accounting systems must reflect the wide variety of organizational structures which have been developed to provide complex health services in a broad array of differing circumstances. For example, some hospitals have personnel in the nursing department performing functions which are performed in other hospitals by personnel in the housekeeping department. Some hospitals have patient meals served by nursing personnel, other hospitals are organized so this is a dietary function. Some hospitals include purchasing and receiving in the fiscal area of the hospital while others are organized so that they fall in a separate cost center.

A hospital accounting system must also meet the legitimate requirements of third party payers (government and non-government) of hospital services for certain accounting information related to the provision of these services. As these requirements have developed, hospitals have been able to adapt their accounting systems to provide the necessary information. External users of financial information usually wish information organized on a functional or output basis. This external information is normally required on an annual basis. External reporting requirements are now met by reclassifying costs originally recorded on a responsibility basis to conform with the functional definitions required by the report.

Management's information needs are primary because of the ultimate responsibility of management and because of the frequency and timeliness of these needs.

EXTERNAL INFORMATION NEEDS CAN BE MET IF DEFINED

In an attempt to simplify the complexities of administering the payment process and assuring equitability, third party payers often assert that mandatory systems of uniform accounting and reporting for hospitals would provide a degree of comparability that would facilitate the review and payment of claims for reimbursement for hospital services.

There is an assumption that uniform reports derived from uniform accounting will allow a third party payer to compare one hospital with another. While broad comparisons may be desirable, artificially forcing accounting and reporting for hospitals into a single mold would yield uniform numbers and statistics which, for comparison, could be highly misleading. For example, at the ridiculous extreme, blind comparison of nursing costs in a hospital that served exclusively terminally ill cancer patients with such costs in a hospital that served only the usual medical-surgical patients, could lead to the conclusion that the personnel in the cancer hospital were highly inefficient.

A degree of comparability can be achieved to the extent that third party payers develop clear definitions of the information required to be reported. While the development of uniform definitions is not an easy task, it is less costly and less intrusive on the needs of management than attempting to mandate a uniform accounting system on an entire industry.

Reports by business to the SEC or to taxing authorities show that some degree of comparability is possible without uniform accounting. The difficulties in obtaining clear definitions in these situations also illustrate the complexity of obtaining absolute conformity.

Financial data required for external reporting can be provided by a flexible accounting system that also considers the unique hospital requirements. Independent audits of the information reported will ensure its validity.

WITHOUT SUFFICIENT SPECIFICITY, ANY SYSTEM WILL BE NEEDLESSLY COSTLY

When considering the type, size, programs, level of care and many other factors, hospital dissimilarities exceed their similarities. The over 7,000 hospitals in this country vary by ownership (investor-owned, not-for-profit), by sponsorship (religious, community and governmental), by services rendered (medical, surgical, obstetrical, therapeutic, rehabilitative, etc.), by specialization (children's, cancer, psychiatric, etc.), by organizational structure and other factors too numerous to mention.

A uniform system, if developed, will have to meet an infinite number of internal reporting requirements. Present efforts are also attempting to meet not only this diversity but also attempting to meet any possible information needs for any state or federal program in existence or yet to be devised. The result is bound to be that more information than is needed will be recorded, classified and summarized. This excess cost would come at a time when there is general understanding that paperwork burdens are stifling american industry including hospitals.

RESEARCH IS NEEDED

A uniform functional system should not be mandated without a thorough analysis and weighing of the claimed benefits and the possible adverse consequences. There should be an assessment of whether the objectives sought by a mandated uniform functional accounting system can be achieved with other less drastic and costly alternatives.

THE HFMA PRINCIPLES AND PRACTICES BOARD

The increasing complexities of accounting, the growing regulation of the health industry and the proliferation of agencies and organizations which influence health care accounting principles and practices have caused concern for many of our members. In October 1974, the HFMA Board voted to form a task force to examine accounting principles and practices insofar as they apply to the health care industry and HFMA's role in formulating positions on issues related to these principles and practices.

In 1975, HFMA created a Principles and Practices Board consisting of the twelve best qualified individuals in our field to study issues of concern. One of the subjects studied by the Board is the general subject of uniform accounting and reporting. This study was begun long before this piece of legislation was introduced and was not undertaken in specific reaction to it but is applicable to it.

There are three distinct stages in the development of a position statement by HFMA's P&P Board. First, a background paper is prepared. The purpose of the background paper is to document views on the issue under consideration from a variety of sources as an aid to a thorough understanding of the issue.

Armed with a thorough understanding of the background, a discussion memorandum is prepared, detailing the various questions related to the issue and the alternatives to those questions. A discussion memorandum makes no judgements on the alternatives enumerated but offers them to stimulate discussion of the issue. Selected background or authoritative references are included. Each HFMA member is requested to review the questions and alternatives closely and express their preferences and rationale.

After review of the comments received in response to the discussion memorandum, an exposure draft of a position statement on the issue is prepared. The exposure draft sets forth a conclusion tentatively judged acceptable by the Board. The exposure draft is distributed to those who have an interest and concern including members, other individuals, and organizations. All readers of the exposure draft are urged to read it extremely critically, pointing out not only basic disagreements, but omissions, phraseology that may be misunderstood, or any other matter that the reader feels the Board should consider before adopting a final position.

These three steps have been completed with respect to uniform accounting and reporting. A position statement on this subject is expected to be issued in a very few weeks which considers all the comments received. We trust that the Committees will study the conclusions of this group carefully when available.

HFMA will be pleased to work with the committees and their staffs as we have been working with the staff responsible for implementing Section 1533(d). Task forces of our members are, at this time, making a detailed technical review of the proposed Chart of Accounts. This review is part of our ongoing program of work with the staff. We have been actively involved in all aspects of this program and can provide technical review of the aspects of the proposal which will make the difference between fulfilled or unfulfilled expectations.

STATEMENT OF JAMES A. HARSHMAN, M.D., CHAIRMAN, BOARD OF TRUSTEES, INDIANA STATE MEDICAL ASSOCIATION

We are most grateful for the opportunity to submit our views of HR 3, the Medicare and Medicaid Anti-Fraud and Abuse Amendment. We were also quite surprised to learn that written testimony was cut-off so soon after the hearings were completed. Such constraints on testimony work hardships on Associations such as ours which has no liaison office in Washington, D.C. We are hopeful that these comments will be accepted and made a part of the permanent record.

Our Association is a non-profit voluntary organization of Indiana physicians with headquarters in Indianapolis, IN. We have over five thousand (5,000) members representing all specialties who practice in virtually all known types of practice settings.

The Indiana State Medical Association has taken a strong position against fraud, and our Association has supported the statement which the American Medical Association adopted at its annual meeting last June that condemned and deplored all acts of fraud and wrongdoing. Fraud is clearly a criminal act and those convicted of fraud should be penalized to the fullest extent of the law. Abuse is much more difficult to define and no where in HR 3 is the term defined. What is abuse to one physician may be a standard method of practice to another physician. To ferret out acts of abuse among all physicians would be to allow fishing expeditions into practically every facet of their practice. Such expeditions without a clear definition of abuse would, in our opinion, be counterproductive and in fact would drive physicians away from providing services to Medicaid and Medicare patients to avoid further intrusion into their practices in the future.

The Indiana State Medical Association shares your goal to improve federally financed health care programs and to rid these programs of unscrupulous providers. We believe the vast majority of the physicians are honest, dedicated practitioners who are anxious to provide the highest quality of health care to their patients. We are concerned that many of our physicians would be harmed by this legislation unless protective measures and definitions are included.

Section 3, Disclosure of Ownership and Financial Information, affects virtually every physician except those in solo practice which would seem to imply that fraud and abuse exists everywhere except in the individual practitioner's office. We believe this section should be amended to indicate that disclosure of ownership and financial information be required only by those physicians associated with "Medicaid mills" and those whose profiles of practice as identified by computerized or manual peer-review systems, have characteristics of a situation in which fraud and abuse could occur.

We would like to respond to the section of the Social Security Act, 1125, which deals with "shared health facility." The definition of shared health facility is much too broad, and again, it encompasses all physicians who are not in solo practice, which would include over fifty per cent (50%) of the practicing physicians in the State of Indiana. A provider that is intent of frauding the government will do so, whether in a solo practice or in a shared health facility. The insertion of a newly defined practice setting, shared health facility, would only require that he change his modus operandi. and thus fall outside the bounds of the net. Again, such unscrupulous providers can only be identified by examining practice profiles by their peers.

Section (3) (A) Establishing Trigger Amounts Which Would Include a Physician for Examination is unreasonable. Many honest physicians have billings in excess of five thousand dollars ($5,000.00) in any one month, and thus would be investigated. Batch billing, vacation schedules of all office personnel, and computer breakdowns could all be factors beyond physician control, that could result in monthly billings in excess of five thousand dollars ($5,000.00). Practically all of our physicians practicing in the inner city and ghettos would be included in such federal investigations. While billings of five thousand dollars ($5,000.00) per month or forty thousand dollars ($40,000.00) per year may seem to be a large amount, no provision is made in the Act for adjustments of these limits. As you know, total health care costs between 1965 and 1975 rose eighty billion dollars ($80,000,000,000.00). Yet fifty-three percent (53%) of the increase was due to inflation, which was largely caused by deficit spending on the part of our Federal Government. If this trend continues, by 1985 a monthly triggering amount of five thousand dollars ($5,000.00) per month might cause all physician finances to be examined. Such a federal intrusion could only damage hard working honest physicians. Rather than set definite triggering amounts, examination of practice profiles and patterns by peer review would be more reasonable and effective in identifying fraudulent activity.

Section 6 of HR 3 which gives to the Comptroller General the power to issue subpoenas should be eliminated. The office of the Inspector General of the Department of Health, Education and Welfare has already been given that power, and to further distribute the power to subpeona would only dilute the Inspector General's strength, and provide another mechanism to allow snooping into the affairs of physician's office practices. No purpose is met by giving the authority of subpeona to two (2) federal offices.

Finally, we have a couple of comments on the section amending the Social Security Act dealing with PSROs. Extensive amendments of this section would have to be made in order to insure proper functioning of these organizations. To place added responsibility on them would only confuse the situation. Practically all of them are in their formative stage. Safeguards to insure confidentiality of PSRO records should be provided. Amendments to allow physician associations or organizations to perform PSRO activities should be accomplished.

On behalf of the Indiana State Medical Association, we appreciate this opportunity to present the views of our members on this very important piece of legislation.

STATEMENT OF ROBERT J. KENNETH, PRESIDENT OF KENNETH ASSOCIATES, SAN FRANCISCO

SUMMARY

Section 2 of H.R. 3, which will prohibit assignment of payments to providers, should not be enacted as it stands. The arguments in favor of this proposal, which focus upon resulting frauds and program costs, do not properly take into account the marginal benefits and costs arising from the use of this security device. I respectfully submit that:

1. There will be no increased opportunity for fraud attributable solely to the allowance of assignment, because the requisite audit procedures will more easily detect fraud by an assignee than fraud by a provider.
2. Program costs will necessarily be decreased, not increased, if an assignment is used to secure payment by the provider, because the provider will choose the more economical arrangement.
3. Any increase in administrative problems will be minor.
4. Alternative security devices will not be as effective.
5. Streamlined processing by the government is not a feasible solution.

Furthermore, I urge Congress to adopt the alternative amendments included herein which will clarify existing law and expressly allow assignment of provider accounts subject to safeguards to protect the government's interest in the ease of administration of an assignment system.

INTRODUCTION

Mr. Chairman and members of the Subcommittee: My name is Robert J. Kenneth. I am the President of Kenneth Associates, the leading firm in the San Francisco Bay Area in the field of hospital business office management. My office is located at 1704 Irving Street, San Francisco, California 94122.

The views on H.R. 3 expressed herein are based upon extensive experience working with providers in the Medicare and Medicaid programs, including twenty-four hospitals, which utilize our services in connection with processing and collecting their accounts receivable.

My primary concern is with Section 2 of H.R. 3, which will prohibit assignments of Medicare and Medicaid payments, except in connection with the provision of billing services for a fee not related to the amount of billings or collections and not dependent upon actual collection. The effect of this change will be to prohibit use of an assignment or power of attorney (which are in essence security devices) in connection with loans against provider accounts, outright purchase of such accounts ("factoring"), or the provision of billing services under an incentive fee arrangement. I believe, in light of my experience and contacts with providers, that all of these can be beneficial services to providers in solving their very real cash flow problems and that the greater security of the agent or lender provided by an assignment can only lower the cost of these services to the provider.

My presentation first analyses and rebuts the arguments in favor of enactment of Section 2 as it stands. The key reason for the prohibition of certain assignments in previous legislation (Public Law 92–603 of 1972) was concern about whether assignment contributes to fradulent practices in billing for program services; it will be demonstrated that the opportunity for fraud is a function of the degree of auditing integrity and is not related to the assignability of accounts. Similarly, other supposed problems such as added costs and recovery of overpayments wil be shown to either be imaginary or to arise from causes other than the allowance of assignment. Furthermore, the proposed solution to these cash flow problems—mandated rapid payment under Medicaid—in my view will not work.

Even apart from the proposed changes, there is a need to clarify existing law. I propose herein alternative amendments which will expressly allow assignments of Medicare and Medicaid accounts, but which incorporate safeguards to satisfy the government's interest in ease of administration of assignments by providers.

I respectfully urge that Section 2 not be enacted as it stands and that serious consideration be given to the advantages provided by assignments and to passage of amendments along the lines herein proposed.

SECTION 2 OF H.R. 3 SHOULD NOT BE ADOPTED

The original Medicare and Medicaid laws (Public Law 89–97 of 1965) did not prohibit assignments and in fact assignments were accepted in the programs until 1972. In that year, amendments to Medicare Part B and Medicaid were adopted (Public Law 92–603) which prohibited payments to "anyone other than" providers of services. The legislative history indicates that this prohibition of assignments did not apply to payments "based on the reasonable cost of the services' of a provider. These aspects of existing law are discussed more fully hereinafter.

Section 2 represents a more precise attempt than was evident in the 1972 amendments to prohibit factoring. It will amend the same two subsections which were amended in 1972 (Social Security Act §§ 1842(b)(5), 1902(a)(32), 42 U.S.C. §§ 1395u(b)(5), 1396(a)(32)) by adding to each a sentence which expressly bans the use of assignments and powers of attorney in relation to program payments, while at the same time creating an exception for assignments in connection with provision of billing and/or collection services for a fee that is not related to the amount of the billing and is not dependent upon actual collection. Thus, the section changes existing law by shifting the focus of the exception from the reasonableness of the provider's charges to that of the agent's charges. In addition, a similar change will be made under Medicare Part A, by adding a new subsection (c) to section 1815 of the Act.

Assignment and factoring of account receivable have been common business practices in virtually all industries for many years. They enable a business to improve its cash flow (thus reducing interest expense) and place the billing and collection efforts in the hands of specialists who ordinarily can perform these functions much more economically than can an individual business. While lending and collection are separable functions, they are also naturally combined. In my own case, hospitals for whom I presently provide billing services have asked if I might also arrange advances against accounts so as to reduce even further their payment delays. I must emphasize that the cash flow squeeze is particularly acute in the health care industry.

Despite the economic advantages to providers that factoring allows, several arguments have been raised to support an outright ban on assignments, and hence a ban on services that rely on the security provided only by that device.

There are two principal statements of the policy analysis behind the 1972 amendments and, therefore, behind section 2:

1. Senate Finance Committee Staff Report, "Medicare and Medicaid—Problems, issues, and Alternatives," 91st Cong., 2d Sess. 130 (1970) (Exhibit A hereto); and
2. Senate Finance Committee Report, "Social Security Amendments of 1972," to Accompany H.R. 1, 92d Cong., 2d Sess. 204–05 (1972) (Exhibit B hereto).

These documents reveal five principal arguments against allowing assignments of accounts:

1. Assignments present an opportunity for greater fraud and abuse, by way of incorrect and inflated claims.
2. Assignments create an additional cost to the provider which is indirectly passed on to the programs.
3. Assignments create additional administrative problems for the government, principally in the area of recovery of overpayments.
4. Providers can borrow against their Medicare and Medicaid receivables anyway without resort to outright assignment of claims.
5. The proper solution to the provider's desire for prompt payment lies in streamlining processing of claims by the government and intermediaries.

These five arguments are rebutted hereafter in turn.

1 There Is No Increased Opportunity For Fraud Attributable Solely To The Allowance of Assignments

The legislative history places primary emphasis upon past abuses as a rationale for abolishing assignments. It is argued that since Medicare and Medicaid frauds have involved both overbilling and assignments, therefore overbilling will be reduced if assignments are prohibited. Yet in this syllogism the premises do not support the conclusion. Although in a simplistic sense an assignee is one additional person in the chain of claims submission, no significant increase in attempted program fraud is likely to be created thereby because a sound auditing program will detect fraud by whomever it is committed. The audit process for detecting abuses by dishonest billers and punishing the offenders is essentially the same, whether it be providers or assignees who are billing and collecting for the services rendered. No greater level of auditing intensity will be required with assignments than without; in fact, it appears that fraudulent billings by assignees would be detected more easily than those by providers.

The prevention of fraud in Medicare and Medicaid billings is not essentially different from any other type of crime prevention—the potentially dishonest party has to be aware that he or she has a good chance of being caught, and that the penalty will be severe enough to make it unwise to commit the crime. This requires a sound auditing theory and design, plus credible communications to all involved about the effectiveness of the system and the penalties for violation. The HEW Office of Inspector General, provided for under Section 201 of Pub. L. 94–505 (October 15, 1976), should be charged with responsibility for establishing such audit procedures to the extent necessary to preclude most abuses.

I will make a few suggestions as to the necessary audit measures, dealing first with those related to hospitals and then with those related to physicians. I will also illustrate why these functions are totally unaffected by the party doing the billing, whether provider or assignee.

The audit of the propriety of the hospitals' billings should consist primarily of a visit to the hospital and examinatiton of medical records and physician authorizations for services rendered, including review of the "utilization review" function at any given hospital. This could be done for all billings if deemed necessary but, more practically, it would be limited to a percentage of cases selected by a reliable statistical sampling technique. Additionally, confirmations could be requested from program beneficiaries that they received the service billed; however, this may not be as satisfactory because many program beneficiaries are not aware of the charges for services received in a hospital. An additional technique would be to ascertain that a claim for a particular patient's hospital stay was not submitted twice. This should ordinarily be easily detected by the programs' fiscal intermediary by matching claims for a given patient to see that payments made for a specific stay or date of service were not duplicated. Moreover, advance approvals are now obtained from the programs for each stay.

There are at least two audit techniques for physicians available. The most productive technique would be to ask program beneficiaries, probably on a test basis, to confirm services received. Such a confirmation might list the amounts paid to and services provided by a certain doctor in a certain month, together with a request to the patient to please notify the Department of any discrepancies "so that your Medicare (Medicaid) account can be properly adjusted." This type of confirmation should uncover incidents of overbilling or billing for services not rendered. For example, if a patient had a finger x-rayed, but the program had been billed for a chest x-ray, the patient might reply something like "no chest x-ray done, my left index finger was x-rayed once," which would lead to further investigation.

The second technique useful for an audit of physicians would entail visits to their offices and inspecition of their medical records, but this would probably not be as effective.

The important point is that the above procedures would not be any different for a provider of service who assigns accounts receivable than for one that does not assign.

Actually, a fraudulent assignee could probably be more easily detected than fraudulent provider. Consider the possible methods that could be used by an assignee to defraud the programs: (1) the amount of the charges could be raised from those submitted by a provider; (2) the assignee could bill for services not rendered; or (3) the assignee could double bill for services rendered. In case (1), as soon as an auditor visited the provider's office and discovered that the provider's bill for services was greater than the records showed, the fraud would be immediately discovered. Or, in case (2), if a nonexistent hospital stay is billed, that fact would become immediately obvious. In all cases the provider has the greater opportunity to initiate fraud and the mechanism needed to detect fraud is the same.

No double audit will be involved because the above auditing techniques can be carried out solely at the offices of the provider, and with the proper audit system, there is absolutely no increase in opportunity for fraud due to the assignment of claims. A provider has a much greater ability to manipulate medical records than an assignee has to raise amounts supplied to him by the provider. While we do not have access to any details of the frauds referred to in the Staff Report and Committee Reports, we are convinced that the key problem in all of them was a defect in the basic auditing system rather than any problem arising from assignments. The corrective legislation needed for this problem relates to audit design, not the identity of the payee.

2. Program Costs Are Necessarily Decreased, Not Increased, If Assignments Are Used

The second reason for the denial of assignment, that the Medicare and Medi-Cal programs would pay additional costs because of the assignments, is patently false. If the provider determines that assignment is financially advantageous to him, after evaluating the costs of assignment and/or factoring against the costs of not doing so, it is obvious that the cost to the government programs will also be proportionately less, in terms of interest expense and billing and collection expense. In most cases experienced assignees are specialized and can do a more efficient job of billing than is possible by most service providers. The assignee's charge is counterbalanced by these efficiency improvements; furthermore, the agent's fee can only be lower if it is secured by an assignment than if the agent is taking more risk of nonpayment. Likewise, there must be interest expense savings to the provider in the case of factored accounts, or else the services will not be usd.

The language in Section 2 infers that a problem is created by an agent (or assignee) charging in proportion to the amount billed. This manner of charge is common business practice. The fee arrangement does not change the conclusions relative to fraud or cost discussed above. Presumably, the provider will have concluded that for his operations (whether hospital or otherwise) the arrangement is financially advantageous.

I will illustrate the factors that go into this cost calculus by reference to the typical service which my organization provides. Our overall objective is to increase hospital cash flow. This is done by developing effective policies and procedures for a hospital's business office operation and its interface with other hospital departments. Specifically, Kenneth Associates assists hospitals in developing and implementing improved procedures for the preparation and submission of billing claims, principally (but not exclusively) Medicare and Medicaid (Medi-Cal) claims. Our own personnel sometimes perform the hospital's billing operations and may also perform follow-up services, such as revision of claims, contesting claims, and collection agency referrals. More frequently, our staff trains a hospital's personnel to perform these functions. Another variation in service involves specific oversight of billing operations. Our usual method of operation is to establish a target figure of average days revenue outstanding and then to reach the target by a combination of improvements in internal efficiency and improvements in approaches to government and third-party payors.

Our success has been outstanding. For example, since 1971, we have recovered twenty million dollars ($20,000,000) for San Francisco General Hospital. at a cost to the hospital not exceeding three hundred thousand dollars ($300,000).

Our customary fee arrangement for billing services is based upon a specified percentage of the billings and is conditional upon successful collection of the accounts. This formula is advantageous to the provider because it gives the agent an incentive to increase the accuracy and timeliness of claims submissions, which is after all the principal benefit which the agent provides. If these two incentives are taken away, as Section 26 would do in situations where the agent desired to take an assignment to secure his fee, the agent must be paid either at an hourly rate or on a piece-work basis, neither of which have any built-in incentives to the agent which would be attractive to a provider. The structure of the proposed exception operates on the premise that claims submission is a routine clerical process, while in truth the amount of to be recovered from any given billing is very much in flux and the skill which the billing agent brings to this task, both in terms of accurate filing (to avoid subsequent resubmission) and of proper categorization (so as to miximize revenue), is what creates the value or benefit of his services in the eyes of the provider.

I will concede that the taking of an assignment is not necessary to an incentive fee arrangement as just described. To date we have conducted our business without assignments to secure our fee and we could continue to do so under the proposed Section 2. My points are that the fee with an assignment could only be lower because of a lower risk of nonpayment, and that there is no logic to the structure of the exception written into this bill.

A similar cost calculus is involved in the cases of pure factoring and/or lending on the security of accounts. While we do not presently provide such financing services, we have devised a plan to provide such, in order to assist hospitals in coping more effectively with the current payment delays, which average sixty days under Medicaid. Under the plan, we would arrange an immediate advance of money to hospitals on the security of an assignment of their Medicare and Medicaid accounts. Alternatively, we would arrange the outright purchase of such accounts at a discount, commonly known as "factoring." Using such services, a hospital could receive cash proceeds (less a specified discount) within a matter of days after patient services are performed, rather than months later when the claim is paid. Kenneth Associates is in a position to obtain the necessary financing for this plan through reputable banks at favorable rates because the value of a hospital's accounts receivable is enhanced by the hospital's utilization of our billing services.

It is evident that providers, especially hospitals, currently face a serious cash flow situation and that in many cases they are already engaged in unsecured short-term borrowings against their receivables, or borrowing by such means as delaying payments to suppliers. My proposed factoring plan would be a more economical substitute for such existing financing, rather than a new and unnecessary cost to providers and the programs.

In conclusion, the present cost to providers of delay in receiving payment from the government and intermediaries is very real and is already being passed on to patients and the programs in increased charges and decreased service. The issue to be decided is which cost is greater. In my view, the decision on this issue should be left to each hospital and physician, to be made in light of each one's own immediate economic realities. The only conceivable situation where this type of arrangement would result in higher overall costs to Medicare would be where the agent or assignee were related to the provider of service; in such a case the existing regulations on "related organizations" (20 C.F.R. § 405.427) provide a means to limit the portion of such costs which will be reimbursed.

3. Any Increase In Administrative Problems Will Be Minor

Specific problems mentioned in the Committee Reports were those related to "determinations of reasonable charges and recovery of overpayments." The former matter is but one element of the fraud problem and the solution is the audit system discussed above. Since the claim must in all cases have attached to it documentation generated by the provider and be supported by the provider's internal records, the assignment adds nothing whatsoever to the problem of evaluating the claim, any more than it increases the likelihood of fraud.

Recovery of overpayments is not affected by whether the overpayments were made to a provider or to an assignee. Essentially the government's ability to recover overpayments will always depend upon its inherent control over the provider. The first recourse would be to hold back on those accounts already in the pipe line and due to the provider or assignee. In most cases the amount of this backlog would be far more than enough to cover any retroactive adjustment of payments already made. Assuming that payments are made on the average within thirty days of billing, the uncollected amount at any given time, when considered along with those services rendered but not yet billed to the programs, would approximate ten percent of the annual total volume. As a further control over the provider, the government has the threat of disqualifying the provider from participation in the program. For most hospitals, the Medicare and Medicaid programs constitute such a large percentage of their business that they could not operate without these programs: this threat would receive instant attention.

The important point here, once again, is that the government's remedies are the same whether overpayments were made to a provider or an assignee. The remedy of offset against the provider's billing in process will be effective even in the event that the provider terminates from the programs or the assignee terminates his participation in the assignment, so long as a certain notice period is required during which the government can hold up payments pending a final settlement of accounts. Finally, our information is that program overpayments have in fact become more rare in recent years.

The impact of the federal Assignment of Claims Act (31 U.S.C. § 203 and 41 U.S.C. § 15, amended) on administrative problems has generally gone unnoticed. Even if Congress allows assignments under Medicare, the general federal provisions will still govern the mechanics and will impose administrative safeguards on the practice of making assignments. For instance, an agent supplying billing services will still not be able to take a blanket assignment of all claims but will be limited to taking an assignment of each payment after the check has been issued. A bank or factor will not be able to take assignment of some claims but not others, and will not be able to reassign a claim to still another party.

Most of the administrative problems which have been postulated are not serious obstacles. Strangely enough, Section 2 allows assignment of payments to a certain type of collection agent without any provisions for meeting these alleged administrative problems, indicating that the Staff does not see these as serious matters. I, however, see that the administrative mechanics should be the principal focus of regulatory effort. In my suggested amendments and related comments I have outlined procedures which will make an assignment system workable.

4. Alternative Security Devices Are Not As Effective

One argument against the need for factoring is that providers can effectively borrow against their Medicare and Medicaid accounts receivable by means of devices which do not entail outright assignments. For instance, in the Committee Report, it is stated that even after the 1972 amendments, a provider may have a payment check in his name mailed to some other organization, such as to a bank, for deposit in a special account. Another possibility is that a provider may "list" his receivables as an asset for the purpose of persuading a bank to lend him working capital. Blue Cross Association, Provider Release Bulletin, No. 58–19.

Although the above devices do provide some potential for borrowing against receivables, they do not provide the nearly-perfect security which an assignment offers and hence they entail either lower loan proceeds or higher interest rates than would otherwise be the case. Speaking directly from my experience, I can say that the banks with which I have discussed my proposed factoring arrangment have stated that they would *not* advance the necessary funds to allow the operation *unless* a binding assignment can be obtained, while with an assignment they will advance the funds at a favorable interest rate because the value of the accounts is enhanced by the hospitals utilization of our regular billing services. Thus the assignment is the key hinge of the whole service, and the value of the supposed alternatives is, in fact, illusory.

These arguments do, however, point up a key fact in the debate about the wisdom of assignments, which is that all of the services herein discussed (processing and lending) and all of the potential abuses connected therewith with continue to exist even if assignments are prohibited. That is, submission of claims by an agent and lending against accounts receivable can and will be carried out without the use of an assignment as a security device. The difference that Section 2 will make is that more legitimate agents and banks will be deterred to varying extents, relative to those who will provide the services taking more risks for a greater return.

5. Streamlined Processing by the Government Is Not a Feasible Solution

The Staff's response to the genuine need for "immediate cash," admitted in its 1970 Report, is that "streamlining administration and processing" will make factoring unnecessary. Section 4(a) of S. 3205, introduced last year, which would have added subparagraph (39) (A) to Section 1902(a) of the Social Security Act, attempted to implement this solution by mandating that State Medicaid programs must provided procedures which assure that 95% of "clean claims" shall be paid within 30 days of receipt of the claim from the provider, and 99% within 90 days. If a State did not meet such targets, after notice of deficiency and up to six month's opportunity for correction, it could, under Section 4(c) thereof (subsection 1903(n) to the Act), have its Federal matching funds for administrative costs reduced by 50% or terminated, while a State which substantially exceeds this and one target may have its Federal matching increased to 75%.

My experience with the Medicaid program in California (California Medical Assistance Program, or Medi-Cal) leads me to believe that this 30 day target for payment may be impractical and infeasible. On the average, claims are paid by Medi-Cal after about 60 days and this has been the average for several years. Medicare payments are generally made by SSA in less than four weeks, but Medi-Cal is much slower. Furthermore, California has had a requirement since 1965 that contracts between the Department of Health Care Services and fiscal intermediaries shall provide that payments will be made within 30 days from receipt of documentation. Cal. Welf. & Inst'ns Code § 14104.3 (1971), replacing § 14104(c)(6) (1965). This requirement has been ignored in practice and has never been consistently met in my experience. In fact, § 14104.3 was amended in 1972 (1972 Cal. Stats., ch. 1019, p. 1889, § 1) to provide that notice shall be given to the provider within 60 days if the bill is "held for peer review" beyond 30 days. Even this loophole in the statute has not been compiled with, in my experience, although the theoretical penalty for noncompliance was termination of the contract with the carrier. Cal. Welf. & Inst'ns Code § 14106 (1965, repealed 1972).

While I cannot be certain that Sections 4(a) and 4(c) of S. 3205 would be ineffective, I would suggest that there are serious problems arising from the nature of Medicaid claims evaluation which cannot simply be legislated out of existence. At the least, such a 30 day requirement even if it works is no substitute for a financing plan which provides cash to the provider within a matter of days.

SUMMARY

The policy arguments in favor of abolishing assignments are misdirected because they do not bear upon the incremental costs attributable solely to the taking of an assignment as a security device (which are minimal) and they ignore the benefits to providers which this device allows (which, based upon an assessment of the particular economic situation, may be great). I urge Congress not to adopt Section 2 of H. R. 3.

EXISTING LAW SHOULD BE CLARIFIED

Even if Section 2 is not enacted, there remain serious uncertainties in existing law relating to the status of assignments of Medicare and Medicaid accounts. We feel that Congress should, based upon a full review of the merits discussed above, clarify the law in these respects and expressly state that there is no general policy against legitimate assignments and factoring.

DHEW has taken the position that all assignments of claims under Medicare are prohibited, based upon the language of § 1814(a)(1) of the Social Security Act, 42 U.S.C. § 1395f(a)(1), and has adopted 45 C.F.R. § 249.31 to bar commercial "factoring" of Medicaid claims. Our research indicates that the Department was fully in error when it first adopted its position and remains, despite amendments to the Act, partially in error.

1. Medicare Part A

The original Medicare law, enacted as Public Law 89–97 (79 Stat. 286) on July 30, 1965, created sections 1814(a) and 1835(a) of the Social Security Act (42 U.S.C. §§ 1395f(a), 1395n(a)), which provided that payment for covered services under Parts A and B "may be made only to providers of services" that have an agreement with DHEW under Section 1866 of the Act and only if certain procedural steps are followed. There was no similar language for the Medicaid program.

We respectfully submit that this language was not intended to bar assignments for the following reasons:

(a) This language, on its face, does not bar assignments. It merely limits providers who may participate in the program to those who have an agreement with DHEW and who follow certain procedural steps. It is amenable to the interpretation that payment to an agent or assignee of the provider satisfies its terms. The legislative history repeats the statutory language, but without the word "only," thus further negating the inference that the language was meant to bar assignments. There was no discussion of the problem of assignments at that time.

(b) The applicable DHEW regulation (20 C.F.R. § 405.150) recites that amounts payable under Medicaire Part A are payable "only to a participating provided of services." This regulation is compatible with the above, if it is understood merely as defining certain providers who could claim payments and not as having anything to do with the subject of assignments.

(c) Subsequent legislative material indicates that DHEW did, in fact, honor assignments in the early years of the programs. Senate Report No. 92–1230 (1972) recites, at pages 204–05 (Exhibit B hereto):

"The law is silent with respect to reassignment by physicians or others who provide services of their right to receive payment unde these programs. The Department of Health, Education, and Welfare makes such reassigned payments under medicare without specific legislative authority."

In addition, DHEW comments on Medicaid (Hearings of the Senate Subcommittee on Medicare and Medcaid, 91 Cong., 2d Sess., pt. 1, at 165, 189 (1970)) recite:

"Assuming that independent collection and bill discount agencies now operate legally, legislation will be required to prohibit States from making vendor payments to such agencies from Title –I– program funds."

The premise of this statement is that the original Medicare and Medicaid law did not prohibit assignments, even with the language about "only to providers."

(d) On October 15, 1969, HEW Secretary Finch submitted the "Health Cost Effectiveness Amendments of 1969." They were discussed in the House Ways and Means Committee Hearings on "Social Security and Welfare Proposals," 91st Cong., 1st Sess. at pages 133, 1058 and 2108. The amendments embodied many changes designed to improve efficiency of administration, but they did not include a ban on assignments. Thus, as of that date, the Administration did not view assignments as a problem.

(e) Section 236 of the 1972 amendments to the Social Security Act, discussed below, made no change in Medicare Part A.

Therefore, our analysis of the law shows that assignments of payments under Part A are not prohibited by law, despite the position taken by DHEW.

2. Medicare Part B and Medicaid

In 1972, Public Law 92–603 changed the law to add provisions to the Medicare Part B and Medicaid law to the effect that no payment can be made to "anyone other than" a provider. These changes are now found at 42 U.S.C. §§ 1395u-(b)(5) and 1396(a)(32). They were followed by regulations at 20 C.F.R. § 405.1680 and 45 C.F.R. § 249.31, respectively, adopted in early 1974. Although the stated language did not differ linguistically from the orignal ("only to providers"), the accompanying legislative history clearly indicates that a partial ban on assignments, particularly in the context of factoring, was intended.

I have two key points to make about these 1972 amendments. First, they were not preceded by a thorough discussion in the public record of the merits of a ban on assignment. Second, the legislative intent was limited to a ban on fradulent assignments.

The effort to prohibit assignmenis originated with a Staff Report of the Senate Finance Committee, entitled "Medicare and Medicaid: Problems, Issues and Alternatives," dated February 9, 1970. The key paragraphs of this Staff Report are set forth in Exhibit A attached hereto. No preceding House or Senate hearings dealt with this aspect of the Report; apparently the information upon which it is based was directed to the Staff informally. Clearly the Staff Report operates on the assumption that, as of that time, assignments were permitted. The principal points made by the Staff analysis are dealth with in the above analysis of Section 2 of H.R. 3.

The Staff recommendations were incorporated as Section 234 of H.R. 17550 in January, 1970. The Senate Finance Committee held hearings on this bill under the title of "Social Security Amendments of 1970" (91st Cong., 2d Sess.) on June 17 and July 14, 15, 1970. The testimony was remarkably muted with respect to the issue of assignments. The American Public Health Association endorsed the ban (page 712), on the grounds that "it will guard against unethical—even immoral—practices." The Blue Cross Association omitted any comment on this change (page 777), as did the American Medical Association (page 1083). The Senate Finance Committee Report on the bill, S. Rpt. No. 91–1431, dated December 11, 1970, sets forth the text of Section 234 without comment.

H.R. 17550 did not pass in 1970, but was reintroduced virtually unchanged as H.R. 1 in the first session of the 92nd Congress. The ban on assignments was designated Section 236. This bill became Public Law 92–603, enacted on October 30, 1972. Hearings on the bill before the Senate Finance Committee, under the title of "Social Security Amendments of 1971," on July 27, 29 and August 2, 3, 1971, contained no discussion on the question of assignments.

The relevant committee reports on this bill are: House Ways and Means Committee Report No. 92–231, dated May 26, 1971; Senate Finance Committee Report No. 92–1230, dated September 26, 1972; and House Conference Report No. 92–1605, dated October 14, 1972. The key paragraphs from the Senate Report are set forth as Exhibit B attached hereto. The wording is nearly identical to that used in the House and Conference Reports, set forth in 1972 U.S. Code Congressional & Administrative News at pages 4989, 5090–91 and 5370, respectively, and the earlier House Report No. 91–1096 dated May 14, 1970. The concerns expressed are similar to those in the above Staff Report.

We cannot find any foundation for the Reports' comments, or even any discussion of the matter, in prior hearings. In short, this important amendment was adopted without a public disclosure of the alleged abuses and without a full discussion of the pros and cons of factoring from the provider's point of view.

The critical sentence in the Committee Report, which is not reflected in the statutory language, states that the ban on assignments does not apply to payments "based on the reasonable cost of the services." Logically this could mean that the cost of the agent's or factor's services must be reasonable, but gramatically the terms "the services" in that paragraph can refer only to services of a provider. Thus, the Congressional intent as expressed in the Committee Reports is that only "incorrect and inflated claims" are not assignable. This is a peculiar proposition, because the remedy for fraud in any case is, immediately, to stop payment and, over the long term, to improve auditing. Yet this reading of the intent relates directly to the concern for fraud expressed in the preceding paragraph of the Report. Any administrative problems arising from the legitimate assignment of claims based upon reasonable costs of the provider were evidently not operative concerns in the 1972 amendments.

Once again, a thorough analysis of the law reveals that the position taken by DHEW—that all assignments are banned—is not supported by the legislative history. I ask that Congress now consider the issues raised on the merits. The following section contains my suggestions about the form of an optimal amendment.

PROPOSED AMENDMENTS SHOULD BE ADOPTED

Exhibit C attached hereto sets forth a revision of section 2 in the form which I believe best responds to the issues raised above. The principal emphasis in drafting, once it is recognized that assignments do fulfill a need of providers, is to devise safeguards to maximize the public benefit of factoring.

As was stated above, the principal concern—fraud—is logically an unrelated problem, for which the solution is auditing integrity. There is little that legislaton can do to provide safeguards against certain abuses that are possible with or without assignments.

An assignment should be permitted pursuant to a court order, in which case any potential problems would be subject to public scrutiny. My amendments allow assignments to be made, in addition, to either the billing agent or a financing institution, but to no other parties, because the incremental benefits to providers are greatest in relation to these two kinds of services, and because allowing other miscellaneous assignees will increase the costs of administering an assignment system. An assignment will not be allowed between two related organizations, as defined in the regulations, so that the fee and interest arrangements will always be the result of arm's-length negotiation.

I considered including percentage limitations on discounts allowable for billing service fees and interest, in order to satisfy the public interest, but have concluded that the exsting program limitations provide adequate protection against unreasonable costs and charges. The determination of disallowance of interest or collection expenses is best left to be handled on a case-by-case basis. Furthermore, setting a fixed maximum discount to cover all situations would be infeasible, in light of the differences, for instance, between the collectibility of in-patient and out-patient accounts.

The federal Assignment of Claims Act provides a satisfactory solution to problems relating to administrative simplicity of assignments. The standards of that general Act (differing as they do as applied to regular agents and financing institutions) are incorporated into my suggested Medicare amendments. These standards briefly provide that any regular assignment of a claim against the United States, or any power of attorney for receiving such a claim is void unless made after the allowance of the claim, the ascertainment of the amount due (which could in the case of these programs be an estimated amount), and the issuing of a check for payment, and unless executed before two witnesses and acknowledged before a public officer (e.g., a notary public). However, assignments of claims to a "bank, trust company, or other financing institution" need not comply with the above procedures, *if* the contract under which the claim arises allows such assignment and provides for payments aggregating at least $1,000, and if (unless the contract excepts these) the assignment covers all unpaid amounts payable under the contract and is not made to more than one party or made subject to further assignment (but it may be made to an agent of two or more parties participating in the financing). In the event of such a bank assignment, written notice and a copy of the assignment shall be filed with the contracting agency and the surety and disbursing officer, if any.

Because Medicare provider contracts are open-ended in duration, it is impractical to assign "all amounts" payable until the end of participation in the programs. In order to conform with these federal provisions, the contracts will have to be revised to permit assignment of less than all amounts payable. My suggestion is contained in the amended text: the contract will permit only assignments that cover all amounts payable either until a fixed date or until a fixed number of days (at least 90) after notice of termination is given to the payor.

In the case of Medicaid accounts, the law of the State in which the assignment is made should provide comparable protections.

CONCLUSION

This presentation of the pros and cons of assignments and factoring has shown that cost of the incremental costs of an assignment system are insubstantial when compared with the potential benefits of such a system during the current cash flow crisis faced by providers, and that in any case such an economic decision should be made on a case-by-case basis at the level of the individual facility. The only true incremental cost to the government is the administrative expense of keeping track of assignments. Legislation should attempt to minimize this factor without abolishing a practice which fulfills such an urgent need of providers. Therefore, I urge that the approach embodied in Section 2 should be abandoned and that amendments along the lines I have suggested should be adopted.

EXHIBIT A

[Excerpt from Senate Finance Committee Staff Report, "Medicare and Medicaid—Problems, Issues and Alternatives," 91st Cong., 2d Sess. 130 (1970)]

END PAYMENTS TO COLLECTION AGENCIES

Prohibit making of vendor payments (under medicare as well as medicaid) to independent collection and bill discount agencies—to anyone other than the person or institution rendering the service.

The staff's attention has been called to the increasing usage by physicians, pharmacists, and some hospitals of independent collection agencies to whom they assign their medicaid and medicare billings.

Apart from the opportunity for fraud and abuse which sanction of such agencies affords— criminal indictments have been handed down in New York in one such case—the costs of using those agencies are obviously indirectly passed on to the program.

Such agencies are employed because they offer to relieve physicians, pharmacists, dentists and others of cumbersome paperwork and provide immediate cash for medicaid due bills which the practitioners might otherwise have to wait months to collect.

The solution, however, lies in streamlining administration and processing—including making timely payment—rather than use of costly and problem-creating outside collection and discount organizations.

EXHIBIT B

[Exceprt from Senate Finance Committee Report, "Social Security Amendments of 1972," to Accompany H.R. 1, 92d Cong., 2d Sess. 204–05 (1972)]

PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO BENEFITS (SEC. 236 OF THE BILL)

Under present law, payment for services furnished by a physician or other person under the supplementary medical insurance program is made: (1) to the beneficiary on the basis of an itemized bill, or (2) to the physician or other person who provided the services on the basis of an assignment under the terms of which the reasonable charge in the full charge for the service. Present law also provides that payment for such services under the medicaid program is made to the physician or other person providing the services. The law is silent with respect to reassignment by physicians or others who provide services of their right to receive payment under these programs. The Department of Health, Education and Welfare makes such reassigned payments under medicare without specific legislative authority.

Experience with this practice under these programs shows that some physicians and other persons providing services reassign their rights to other organizations or groups under conditions whereby the organization or group submits claims and receives payment in its own name. Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. Fraudulent operations of collection agencies have been identified in medicaid. Substantial overpayments to many such organizations have been identified in the medicare program, one involving over a million dollars.

The committee concurs with a provision in the House bill which seeks to overcome these difficulties by prohibiting payment under these programs to anyone other than the patient, his physician, or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with the facility in which the services were provided under which the facility bills for the services. Also, direct payment could be allowed to a foundation, association, plan, or contractor which provides and administers health care through an organized health care deliver system. An example of this type of organization would be a prepaid groups prahtice or other system recognized by the State tilte XIX agency. It is not the intent of the committee that this provision apply to payments to providers of services that are based on the reasonable cost of the services.

This provision would not preclude a physician or other person who provided the services and accepted an assignment from having the payment mailed to anyone or any organization he wishes, but the payment would be to him in his name.

The provision would in no way interfere with the fiscal relationship between physician and hospital in the case of hospital-based pathologists and radiologists, for example.

This provision as it applies to medicare would be effective with respect to bills submitted after the enactment date. For medicaid the provision would be effective January 1, 1973, or earlier if the State plan so provides.

EXHIBIT C. ASSIGNMENT OF FEES BY HOSPITALS, PHYSICIANS AND OTHERS

SEC. 2. (a) Section 1815 of the Social Security Act is amended by adding at the end thereof the following new subsection: "(c) Any payment for a service, which under the provisions of this section and the preceding section may be made directly to the hospital or other facility furnishing such service, may be made to a person claiming such payment under an assignment, including a power of attorney, if (but only if): the assignment is established by or pursuant to the order of a court of competent jurisdiction from such hospital or other facility furnishing such service; or the assignments is in favor of an agent of the hospital or other facility furnishing such service (who is not related to such provider), is pursuant to an agency agreement under which compensation is paid to the agent for his services for or in connection with the billing and/or collection of any such payment, and complies in all respects with the Assignment of Claims Act (31 U.S.C. § 203 and 41 U.S.C. § 15, as amended); or the assignment is in favor of a bank, trust company, or other financing institution (within the meaning of said Act), and complies in all respects with the exception provided therein, but the assignment may provide for a portion of the discount to be attributable to services of an agent who provides billing and/or collection services. For these purposes only, the provider's contract shall be deemed to provide for payments aggregating $1,000 or more and shall be deemed to permit an assignment of all amounts payable under the contract until a fixed date at least 90 days after the date of assignment or until a fixed number of days (at least 90) after notice to the payor of intention to terminate the assignment."

(b) Section 1842 (b)(5) of such Act is amended by adding at the end thereof the following new sentence: "Any payment for a service, which under the provisions of the preceding sentence may be made directly to the physician or other person furnishing such service, may be made to a person claiming such payment under an assignment, including a power of attorney, if (but only if): the assignment is established by or pursuant to the order of a court of competent jurisdiction from such physician or other person furnishing such service; or the assignment is in favor of an agent of the physician or other person furnishing such service (who is not related to such provider), is pursuant to an agency agreement under which compensation is paid to the agent for his services for or in connection with the billing and/or collection of any such payment, and complies in all respects with the Assignment of Claims Act (31 U.S.C. § 203 and 41 U.S.C. § 15, as amended); or the assignment is in favor of a bank, trust company, or other financing institution (within the meaning of the Assignment of Claims Act, 31 U.S.C. § 203 and

41 U.S.C. § 15, as amended), and complies in all respects with the exception provided therein, but the assignment may provide for a portion of the discount to be attributable to services of an agent who provides billing and/or collection services. For these purposes only, the provider's contract shall be deemed to provide for payments aggregating $1,000 or more and shall be deemed to permit an assignment of all amounts payable under the contract until a fixed date at least 90 days after the date of assignment or until a fixed number of days (at least 90) after notice to the payor of intention to terminate the assignment."

(c) Section 1902(a)(32) of such Act is amended—

(1) by inserting "(A)" immediately after "provide that",

(2) by redesignating clauses (A) and (B) as clauses (i) and (ii), respectively, and

(3) by adding immediately before the semicolon at the end thereof the following, ", and (B) any payment for a service, which under the provisions of subparagraph (A) may be made directly to the physician or other person furnishing such service, may be made to a person claiming such payment assignment is estaunder an assignment, including a power of attorney, if (but only if): the assignment is established by or pursuant to the order of a court of competent jurisdiction from such physician or other person furnishing such service; *or* the assignment is in favor of an agent of the physician or other person furnishing such service (who is not related to such provider), is pursuant to an agency agreement under which compensation is paid to the agent for his services for or in connection with the billing and/or collection of any such payment, and complies in all respects with applicable State law relating to the assignment of claims against the State; *or* the assignment is in favor of a bank, trust company, or other financing institution (within the meaning of the Assignment of Claims Act, 31 U.S.C. § 203 and 41 U.S.C. § 15, as amended) and complies in all respects with applicable State law relating to the assignment of claims against the State, but the assignment may provide for a portion of the discount to be attributable to services of an agent who provides billing and/or collection services.".

(d) The amendments made by this section shall take effect on the first day of the first calendar month which begins not less than sixty days after the date of enactment.

STATEMENT OF THE NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

Mr. Chairmen and members of the subcommittees: the National Association of Blue Shield Plans is pleased to present this statement on H.R. 3., the Medicare/Medicaid Anti-Fraud and Abuse Amendments. On behalf of our 70 locally-based, not-for-profit medical care prepayment Plans serving 73 million private subscribers and an additional 12 million persons under government programs, we commend the 96th Congress for pricing high priority on this problem.

Fraud and abuse are repugnant in any form, but they are especially reprehensible in programs designed to assist in the financing of health care for the elderly, the poor and near-poor. Dollars—whether they come from taxation or from the private sector—are not inexhaustable, especially in health care. And fraud and abuse in Medicare and Medicaid mean some of the elderly and the poor are not getting the services they should be receiving. It also means the increasingly over-burdened American taxpayer is forced to carry an even heavier load than necessary. Clearly, this situation calls for prompt and effective action.

Blue Shield has been an integral part of Medicare and Medicaid since their inception just over 10 years ago. The members of the two committees forging this legislation are aware of the role Blue Shield has played in these programs and we are proud of the contributions made by our 55,000 employees.

It is our observation that particularly under Medicaid, fraud and abuse have been significantly more prevalent where the program is administered by a state agency. Where government-financed programs have utilized private carriers in an administrative role, the problem has been far less acute. While it may be difficult to document because it would require a unique opinion poll, we believe that in the case of Blue Shield Plans they have had fewer problems because the providers of care are well aware of our utilization review activities. Checking on such facts as medical necessity and monitoring the utilization profiles of physicians have been part and parcel of our form of medical prepayment system even before Medicare and Medicaid became law.

We are greatly concerned about the revelations of fraud and abuse because they undermine the efforts of both government and the private sector to meet effectively the health care financing needs of our citizens. While the evidence indicates the vast majority of physicians, practitioners and instiuttions receiving Medicare and Medicaid payments are honest, the few that take advantage of these programs do unconscionable harm. They are the social leeches, who unless stopped, will drain away the strength and integrity of the Nation's health care system.

We have reviewed H.R. 3 and we support it as a very positive step in dealing with the problems of fraud and abuse. The following comments are based upon our decade of experience in Title XVIII and XIX programs and our 40 years of experience in administering health care programs. We have limited our comments only to those sections that we feel need to be modified. The changes suggested will, in our view, help to make H.R. 3 an even stronger piece of legislation.

SECTION 3: DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

The National Association of Blue Shield Plans recognizes the need for and supports Congress in its efforts to provide full disclosure of financial relations and potential conflicts of interest. If the integrity of the Medicaid and Medicare programs is to be preserved and the American taxpayer is to be expected to support these programs, disclosure of the financial relationships from those who deal with the profit from these programs is essential.

This section is directed at disclosure of financial and conflict of interest information and in general Blue Shield is supportive of it. However, certain aspects of the proposal appear to be redundant of existing disclosure requirements. In particular the requirements that Title XVIII carriers and intermediaries and Title XIX administrators disclose their officers and directors and any "significant business transaction" they might have between the carriers, intermediary and administrator, duplicate information already availalbe under carrier, intermediary and state Plan contract provisions. In most instances, they are also covered by state regulatory statutes and regulations. Consequently, because the requested information is already disclosed, it is our recommendation that Section 3(a) be amended so that its requirements would not be applicable to Title XVIII carriers and intermediaries and Title XIX administrators.

SECTION 4: PENALTIES FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

We are supportive of the intent of this Section to punish those found guilty of making fraudulent statements, representations concealments, conversion or taking other such actions in connection with the furnishing of services under Medicare and Medicaid. However, we would also suggest the consideration of some alternative prosecutorial action in dealing with individuals so charged, especially where rehabilitative measures appear to be indicated.

SECTION 5: AMENDMENTS RELATED TO PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Since PSRO's became part of the Medicare and Medicaid programs in 1972, Blue Shield has supported the concept. Blue Shield Plans were innovaters in the implementation of Peer Review Committees and Utilization Review programs to assess medical necessity and monitor the utilization of procedures rendered to their subscribers long before their consideration in federal programs. We recognize the benefits in lower cost and better quality of care that can be derived from this type of program. It is our commitment and deep belief in the objectives of the PSRO program that causes us to be concerned about certain sections of H.R. 3. These sections in our view, would weaken rather than strengthen the PSRO program.

The short four-year history of the PSRO program has been a rocky one. No one expected nor should they have expected the instant creation of a nationwide system of professional review for Medicare and Medicaid. The difficulties in securing necessary cooperation between the medical profession, state and federal governments as well as Medicare carriers and intermediaries and Title XIX administrators are enormous and complex. Progress has been made, yet problems still remain.

Therefore, if the original goal of the PSRO concept is to be attained, solutions to any existing problems must stem from the hard work and dedication by the parties concerned rather than avoiding or circumventing the difficulties through legislative amendments that erode the program's statutory foundation.

For example, Section 5(b) of H.R. 3 would essentially lower the standards initially set by the PSRO law for a "conditional" PSRO to be designated as a qualified PSRO. In addition, Section 5(d)(4) and 5(a)(2) would eliminate the "priority" given to "institutional" review.

Presently under Section 1154(a)(i) of the Social Security Act, "the duty and function of each Professional Standards Review Organization for any area (is) to assume, at the earliest data practicable, responsibilit for the review of the professionl activities . . . of physicians and other health care practitioners and institutional and non-institutional providers of care." This change is somewhat modified in Section 1155(g) by giving what amounts to a priority to review "health care services provided by or in an institution."

In order for this level of review to be reached and a PSRO to become qualified, the Secretary is authorized to designate an organization as a "conditional PSRO" and to progressively increase its review functions as the conditionally designated PSRO "becomes capable of added responsibility."

The amendments contained in H.R. 3 destroy the critical priority given institutional review, where by far the greatest portion of the Medicare and Medicaid dollars are spent and the greatest savings expected. It would also allow a "conditionally" designated PSRO to become a "qualified" PSRO by simply "substantially carrying out in a satisfactory manner reviews of services provided by or in hospitals" and submitting an acceptable plan "for progressively assuring over a reasonable period of time such remaining function" as a qualified PSRO is required to perform.

There is no substantial evidence to our knowledge that the importance of institutional review has diminished in the past four years. In fact, the opposite appears to be true. Therefore, we urge that no amendments be accepted which might allow PSRO institutional review to be implemented on the basis of the submission of a "plan" as opposed to actual capacity.

We also urge rejection of proposed Section 5(e) which 1) makes PSRO review conclusive where a PSRO is determined by the Secretary to be "competent," and 2) provides that "no reviews with respect to those determinations shall be conducted for purposes of payment" by Title XVIII carriers and intermediaries and Title XIX administrators. This section would impose unnecessary rigidity in the program.

Under current Section 1152 the Secretary, to avoid duplication of functions and unnecessary review and control activities, is authorized to "waive any or all review certification or similar activities required" under this Act for the provision of adequate review and control. This section provides sufficient flexibility for the Secretary and carriers to work together to assure secondary or backup review capacity. A blanket prohibition against concurrent or secondary review such as that set forth in Section 5(e) of H.R. 3 is not in the best interests of the PSRO program. Secondary review capability, particularly at the early stages of PSRO development is vital and must be maintained. We oppose the adoption of Section 5(e).

We must also object to the fact that when taken together, Section 5(b) and 5(e) could substitute a "promise" or "plan" by a PSRO for active ongoing carrier review. Specifically, the "plan" submitted by a PSRO under proposed Section 5(b) should not be used as the basis for eliminating carrier review under proposed Section 5(e) through the Secretary of HEW's determination that the PSRO is "competent" due to its "plan" to "assume review responsibility." Medical necessity review must exist at all times and "plans" do not substitute for existing programs.

We also urge rejection of proposed Section 5(h) since such legislation is duplicative of existing authority. Section 5(b) provides for the Secretary to implement a data collection system to compile comparative statistics for individual evalhation of PSRO's. Under existing provisions of the PSRO Law

(Section 1163(e)(3)) it is the duty of the National PSRO Council to review the operations of PSRO's and to determine "the effectiveness and comparative performance" of PSRO's and report these findings to the Secretary. Instead of establishing a second duplicative evaluation mechanism, the National PSRO Council (consisting of 11 members who are close to and knowledgeable about the PSRO program) should be allowed to exercise the authority it was granted and provide the necessary evaluations to the Secretary.

SECTION 6: ISSUANCE OF SUBPOENAS BY COMPTROLLER GENERAL

This section would provide the Comptroller General with authority to issue subpoenas requiring the production of any books, records, documents or other information. We certainly support the need for the General Accounting Office to have the tools needed to conduct its functions. However, we urge a careful review of its need be made to assure that the proposed response, i.e., a broad, blanket subpoena power, is essential.

With respect to carriers under contract pursuant to Section 1842, the proposal provides the potential for duplication of already existing federal audit authority. Under the governing contracts pursuant to Section 1842, the Secretary of HEW and the Comptroller General each have authority to audit and review claims payment records regarding payments made by a Title XVIII carrier. There is also similar authority granted to the Office of Inspector General within the Department of Health, Education and Welfare as a result of legislative action in the 94th Congress.

It is our opinion that there already exists sufficient authority for both the Secretary and the Congress to have independent audits and reviews of Medicare carriers. The proposed delegation in H.R. 3 of subpoena authority to the Comptroller General and his subsequent exercise of such authority would essentially duplicate what presently exists.

SECTION 10: CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS FOR MEDICAID PROGRAMS

Section 10 would amend the current Social Security Act by permitting those status wanting the higher level of federal funding to give an "explanation of benefits" notice to program beneficiaries only on a sample basis rather than to all claimants. We recognize that the EOB may be an effective cost control device and a visible anti-fraud measure and we also recognize that its impact might be limited in various circumstances. Therefore, we support this proposed amendment.

However, we urge that the sampling technique implemented by developed in a manner which will permit an evaluation of its uses, paticularly to identify the extent of cost consciousness it brings to beneficiaries, and its effectiveness in deterring fraud and abuse by providers.

We thank you for this opportunity to express our views regarding the matters being considered at these hearings, and urge that you review our concerns as expressed herein during your forthcoming deliberations on this subject.

STATEMENT OF THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES, INC.

The National Association of Chain Drug Stores, Inc. (NACDS) submits the following comments on legislation (H.R. 3) the Medicare-Medicaid Anti-Fraud and Abuse Amendments which are under consideration by the House Ways and Means Health Subcommittee and the House Interstate and Foreign Commerce Subcommittee on Health and the Environment.

NACDS wishes to express the Chain Drug Industry's commitment and willingness to work with Congress and the Department of Health, Education, and Welfare (HEW) toward solving the very serious problems of fraud and abuse that are plaguing federal health care programs. This Association commends Congress for recognizing the need to develop new mechanisms which will help preserve the integrity of these vital programs, increase the benefits to recipients and realize significant cost savings which can be directed at expanding the delivery of quality health care at a reasonable price to the country's 215 million people.

As a national pharmacy association, NACDS represents approximately 200 corporations which operate in excess of 10,000 drugstores and 1500 leased pharmacy departments throughout the United States. Our members, many of which are small drug chains with four to ten stores and our large chair operations that have over 700 pharmacies, are a key part of the health care community. Based on the most recent industry statistics, chain drugstores dispense nearly one-third of the nation's prescription drugs and pharmaceutical services.

In this connection, NACDS on behalf of our entire membership endores the objectives of H.R. 3 and we urge that this measure be approved as expeditiously as possible. In our opinion, passage of this proposal will contitute the first major step toward reforming America's health care delivery system.

With our support of this bill, NACDS wishes to address certain sections of H.R. 3 regarding specific language which we feel may require additional attention. Under the section for Disclosure of Ownership and Financial Information, NACDS recommends that the following wording, "non-institutional or free-standing pharmacy" should be substituted in place of the term "independent pharmacy". It is our feeling that this revision would more accurately describe those entites which are providing prescription drugs and have no affiliation wth providers, shared health facilities, clinics or Health Maintenance Organizations (HMO's).

Secondly, NACDS believes that there should be further clarification regarding the phrase "reasonable access" relative to books and records of such an entity which pertain to the provision of or billing and payment for goods and services supplied or rendered. Our members are indeed willing to cooperate in these matters of financial audits and reviews so that errors can be pinpointed and corrected. We also suggest that either these procedures be addressed in the bill or that the Chain Drug Industry has the opportunity to work with the Department of Health, Education, and Welfare toward the fashioning of a viable financial review program. NACDS further recommends that new longuage be added to this section to insure that all materials, information and prescription records will be treated in a confidential manner by the Secretary, federal inspectors and state review representatives. This information is extremely sensitive, to both the pharmacy which must provide these materials and to the patient whose records may be examined.

Under the section pertaining to Penalties For Defrauding Medicare and Medicaid Programs, NACDS is troubled by the wording, "in cash or in kind". It would seem that various services that pharmacies provide, such as consultation, delivery and recordkeeping, could fall under this definition of "in kind". The Association hopes these services, without stipulations or requirements, will be recognized as being an integral part of the various key professional functions that are provided in connection with the dispensing of prescription drugs.

While NACDS supports the thrust of this bill to provide for more severe penalties relative to kickbacks, bribes and other fradulent activities, the Chain Drug Industry is concerned because this legislation makes no distinction between honest mistakes and outright fraud. In most instances, errors are made because of the lack of clarity and uniformity in the guidelines from the federal government to the states with respect to the Medicaid program. More specifically, the problems of complying with so many different state Medicaid programs is staggering, particularly for our larger chain drug members. For example, Walgreen Drug Stores now operates in 35 states. SupRx Drug Corporation is in approximately 25 states through the country, while Revco D.S., Inc. has pharmacies in 24 separate jurisdictions. NACDS firmly believes that understandable and more uniform guidelines would go a long way to remedy this situation. As a matter of fact, the Chain Drug Industry has always endorsed a uniform system for cost accounting, billings, reimbursement, standard dispensing fees, claims processing, benefits and services as a viable means of reducing errors, waste and duplication while realizing significant financial savings. Te achieve these goals of effective and efficient management, NACDS firmly believes that governmental and industry should begin now to develop such a program.

In the overall review of Medicare-Medicaid Reform, the Chain Drug Industry wishes to point out to this Joint Committee that special attention should be directed at the Department of Health, Education, and Welfare's (HEW) Maximum Allowable Cost (MAC) Drug Reimbursement Regulations which pertain to federal health care plans. It is our opinion that the MAC regulations promote both confusion and inefficiency based on the many variations that are permitted on drug prices and dispensing fees. Furthermore, the MAC program fails to provide for an administrative handling fee for claims processing and a triggering mechanism in reimbursement to reflect any prescription drug price increases from the manufacturer to the retailer. Since the nation's most prominent health care experts are indicating that the MAC program will eventually become the foundation for drug coverage under National Health Insurance, NADCS recommends that the appropriate Congressional Committees review these regulations. It is our firm belief that if certain revisions are made, the federal government will realize significant long term savings relative to its expenditures for drug benefits.

Other areas which NACDS feels Congress should thoroughly scrutinize in its Medicare-Medicaid Reform efforts include excessive physician prescribing, recipient eligibility, state fundng, unnecessary surgery, and the need for better health care planning, particularly hospital construction which many areas have expanded far beyond their needs.

In summary, NACDS believes that a strong national health care program can be achieved at a reasonable cost provided that the federal government is willing to exercise better management controls. Additionally, the federal government should recognize that where competition exists within the system, specifically the retail prescription drug market, there should be the least amount of intervention. Without interference, prices in this sector will remain stable. Thirdly, the Chain Drug Industry is of the opinion that many of the problems confronting the delivery of health care can be surmounted if government will call upon industry's expertise to assist in seeking solution.

NACDS supports this bill (H.R. 3) and we hope that our comments on this measure and Medicare-Medicaid Reform in general will be helpful to the Joint Committee in its deliberations. We appreciate the opportunity to comment on this important issue.

National Association of Community
Health Centers, Inc.,
Washington, D.C., March 9, 1977.

Hon. Paul G. Rogers,
Chairman,
Interstate and Foreign Commerce,
Subcommittee on Health and Environment,
Washington, D. C.

Dear Mr. Chairman: With respect to your recent hearings on H.R. 3, referred to as the "Medicare-Medicaid Fraud and Abuse Amendments," I am hereby asking your consideration on an issue which our oragnization feels is important. We were not prepared to testify at the time of the hearings. Nevertheless, I hope you will give this issue due consideration.

Specifically, I am asking you to exclude from the Section 1125 definition of a "Shared Health Facility" Community and Migrant Health Centers as defined in and authorized under Sections 330 and 319 respectively of the Public Health Service Act. As you know, Health Maintenance Organizations already are excluded.

There are several points I am asking you to consider. For example, this bill is aimed at curtailing fraudulent practices of "medicaid mills." We share your concern and goal here. We would hope, however, the Committee would recognize that Federally-supported Community and Migrant centers are strictly regulated by Federal law and regulations. Moreover, our centers are controlled by mechanisms such as (1) independent financial audits, (2) medical audits and quality assurance controls, and (3) funding criteria which carefully and regularly scrutinize management effectiveness and efficiency.

To be quite frank, I do not feel that Sec. 330 and 319 health centers should be lumped into a general definition applying to unregulated private practices, group practices, and "mills." Further, I am concerned with the implications for the growth and development of community and migrant centers.

When Congress enacted the HMO Amendments last year, we were pleased to note in the section dealing with prepaid capitation for Title 19 contracts, that Sec. 330 and 319 health centers were excluded, i.e. permitted to enter into such contracts as were HMOs, to the exclusion of all other providers. Obviously, the Committees felt that health centers were responsible, well-regulated, and offered at least all of the required Medicaid services. Although the Committees expressed their concern over "Mills," they did choose to recognize Community and Migrant health centers as being different from "providers" in general.

Accordingly, I am urging you to exclude Community and Migrant Health Centers from this definition of "Shared Health Facility." As an alternative, wording similar to that used in the HMO Act PL 94–460 could be used.

Should you wish to discuss this matter further, please feel free to call me, our Executive Director, L. Jerome Ashford, or our staff Policy Analyst, Tom Van Coverden here in Washington—phone 833-9280.

Your consideration is deeply appreciated. Please keep me advised.

Sincerely,

JANICE M. ROBINSON, RN, M.S.,
President.

NATIONAL ASSOCIATION OF COUNTIES,
Washington, D.C., March 7, 1977.

Hon. DANIEL ROSTENKOWSKI,
Chairman,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

DEAR MR. CHAIRMAN: The National Association of Counties (NACo)[1] strongly supports enactment of H.R. 3 amending Titles XVIII and XIX of the Social Security Act to strengthen the capability of the federal government to detect, prosecute, and punish fraudulent activities under Medicare and Medicaid programs. We respectively request that this statement be incorporated into the hearing record on H.R. 3.

NACo is supporting H.R. 3 because it believes the bill will significantly reduce the amount of fraud and abuse currently found in both Medicare and Medicaid. Counties have a large stake in both programs, particularly Medicaid. Counties spent $1.2 billion last year in Medicaid alone. The figure does not include costs of services provided to persons falling between the Medicaid gaps—the working poor, transients, illegal aliens, disabled but working persons, prisoners, and others. Furthermore, several other county financed areas (alcoholism, drug abuse, emergency care, preventive and health promotive services) are not covered by either public (Medicare and Medicaid) or private health insurance programs.

As health care costs increase, counties are being forced to rely on an already burdened property tax to support the health care of a small segment of the population. While committed to the provision and availability of health care for all citizens, counties face the dilemma of sacrificing other necessary and mandadted service responsibilities to the burgeoning fiscal requirements of the Medicaid program. Cutbacks in services and/or eligible population provide no relief for counties, which are traditionally the providers of last resort. We believe that H.R. 3 will provide needed fiscal relief in the form af savings as a result of federal/state/local fruad and abuse control programs.

In summary, NACo stands ready to support the enactment of H.R. 3. If you have any questions about our position, please contact Mike Gemmell of the NACo staff.

Sincerely,

TERRANCE PITTS,
Chairman, Policy Steering Committee,
Supervisor, Milwaukee County, Wis.

NOTE: An identical letter was sent to Hon. Paul G. Rogers.

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[1] NACo is the only national organization representing county government in the United States. Its membership spans the spectrum of urban, suburban, and rural counties which have joined together for the common purpose of strengthening county government to meet the needs of all Americans. By virtue of a county's membership, all its elected and appointed officials become participants in an organization dedicated to the following goals: improving county government; serving as the national spokesman for county government; acting as a liaison between the nation's counties and other levels of government; and, achieving public understanding of the role of counties in the federal system.

NATIONAL CONFERENCE OF STATE LEGISLATURES,
Washington, D. C., March 16, 1977.

Hon. DAN ROSTENKOWSKI,
Rayburn HOB,
Washington, D.C.

DEAR CONGRESSMAN ROSTENKOWSKI: At its last meeting the State-Federal Assembly of the NCSL closely examined the ingredients of the "Medicare and Medicaid Anti-Fraud and Abuse Amendments" under consideration by your subcommittee.

Fraudulent activities within Medicare and Medicaid divert scarce resources away from needed services and tarnishes the overall integrity of these programs. Therefore, in trying to restore confidence in these programs through greater focus on fraud and abuse detection. I might add that several states have been working very hard in these same areas and would welcome federal cooperation and technical assistance.

The provisions relating to the Professional Standards Review Organizations (PSROs), however, are of major concern to us. Specifically, we feel strongly that PSRO review should not be conclusive with respect to the necessity and appropriateness of care. We question the wisdom of PSRO involvement in Medicaid administration so long as the PSROs will operate independent of state authority and can exercise substantial control over state medicaid services and payments. Our State-Federal Assembly would like to suggest some alternatives to the PSRO provisions outlined in H.R. 3.

(1) State monitoring of PSROs should be formalized and mandated. (State monitoring could be achieved through the Surveillance and Utilization Review component of the Medicaid Management Information System.)

(2) States already operating utilization review should be allowed to continue, with federal matching payments provided to support that activity.

(3) A process for states to appeal PSROs' decisions should be established.

(4) PSROs should not be granted the ultimate authority over review of medical necessity and appropriateness. Rather a procedure should exist which would permit joint determinations by the state and the PSRO.

(5) States should be allowed to function as PSROs where no current activity exists.

(6) An exchange of data and information between the state and the PSROs should be mandated.

For your information, the State-Federal Assembly (SFA) has primary responsibility for developing NCSL public policy positions on national issues of importance to state legislatures. The SFA is composed of approximately six hundred legislators, representing each one of the nation's state legislative bodies.

Sincerely,

Representative IRVING STOLBERG,
(*Connecticut*) *Chairman, Human Resources,*
Committee of the State-Federal Assembly.

STATEMENT OF JOHN F. HORTY, PRESIDENT OF THE NATIONAL COUNCIL OF COMMUNITY HOSPITALS

My name is John F. Horty. I am President of the National Council of Community Hospitals, an organization of non-profit, community hospitals that assesses Federal legislative and administrative proposals which affect community hospitals and expresses its independent views on those proposals.

NCCH's comments are limited to Section 3 of H.R. and H.R. 3023, particularly to the effect that Section would have on hospitals. Pursuant to that Section, the Secretary of HEW and the Comptroller General would be authorized to request information about the officers and directors and, where applicable, the owners of, hospitals that is intended to be helpful in uncovering harmful conflicts of interest and fraud and abuse.

The goals Congress seeks to achieve in Section 3 are laudable. There is no reason why the public should be saddled with the payment of the unnecessary and dihonest costs associated with any fraud and abuse of the Medicare and Medicaid system. However, I am here today because Section 3 of the bill in its present form jeopardizes non-profit hospitals' ability to attract the most competent persons to serve on their Boards of Trustees, and in its present form is not the best way to discover any fraud or abuse that may in rare instances occur in non-profit, community hospitals.

Charges of fraud, abuse, or conflicts of interest make sensational headlines; sensational topics which capture the reader's interest. The facts never catch up with the charges. On the other hand, the fact that a community leader is willing or unwilling to serve on a hospital board would be largely ignored by the press and public. Nevertheless, hospitals need strong management more than ever before. We must, therefore, strive to encourage the most qualified persons to work on hospital boards and we must protect them from mere fishing expeditions without prior evidence or some reason for a specific concern.

I know of no hospital board that would object to any request by the Secretary for information about related dealings where the request is necessary to determine reasonable cost or where there is some suspicion of fraud or abuse. However, Trustees of non-profit hospitals strongly object to any provision that implies wrongdoing in every related transaction or that associates them with fraud and abuse merely because of their service on a hospital board. Section 3 of H.R. 3 and H.R. 3023 contains such an implication. It is prejudicial to efforts to strengthen hospital management.

At the same time, Section 3 will not assist the effort to detect hospital fraud and abuse. Hospitals are already subject to detailed Medicare audits during which their activities are subject to close scrutiny to determine whether the limitations of "reasonable cost" have been observed. In addition, Congress last year enacted P.L. 94-505, which creates the post of Inspector General within HEW and authorizes him to obtain by subpoena any information needed to ferret out fraud or abuse. If HEW, its fiscal intermediaries, and its Inspector General cannot determine during the course of the audits and investigations they already are authorized to conduct whether fraud and abuse is occurring, I do not foresee that Section 3 of the bill will materially increase chances of unearthing improper transactions.

I fully realize that institutions or persons other than hospitals—who may not be presently subject to Federal audits—are covered by this bill, but even these may be investigated by the Inspector General. Even so, with respect to these institutions, the power conferred by Section 3 to gather information may be of help. But there certainly is no reason to subject hospitals to Section 3. However, if these committees nevertheless believe that hospitals should be included in Section 3, we would ask that the Section be written in a way that will not impair non-profit hospitals' ability to attract and retain strong boards.

Allow me for a moment to try to place into context my concerns. In many communities, transactions between hospitals and local businessmen who serve on hospital boards are a necessity because of the unavailability of other supply sources and the need for these individuals' leadership. In almost all of such cases, the transactions are fair and open. In many cases, they are in fact highly beneficial to the hospital. They allow the hospital to gain advantageous prices and better service from a person who is aware of and interested the hospital's problems because he is on the board.

It is my understanding that the purpose of this bill is not to preclude such transactions, but merely to give the Secretary of HEW the opportunity to investigate particular transactions should the need arise. Moreover, it is my understanding that the bill is not intended to authorize the Secretary of the Comptroller General to send out questionnaires to hospitals selected on a sample basis or to every hospital. Instead, as I understand it, Section 3 of the bill was designed to uncover cases of fraud and abuse when there is some reason to believe that such instances may exist. Although substantial improvements have been made in Section 3 from the corresponding language contained in earlier bills, the bill still does not accurately reflect this intent. Under the literal terms of the language of Section 3 of this bill, investigations could still be launched upon bureaucratic whim and without probable cause against all non-profit hospitals. The mere launching of such an investigation and the attendant publicity could injure Trustees' reputations—even if they were entirely innocent of any wrongdoing. It could subject them without cause to suspicion by the very members of the community they seek to serve.

I refer you specifically to the language in proposed Section 1124 which requires hospitals to comply with any request within the scope of the Section "specifically addressed" to it. This language was added to the bill since its last draft, which came before these Committees in the last Congress (H.R. 15536), in order, as I understand it, to eliminate the possibility of a random sampling or a request of all hospitals. We appreciate and strongly endorse that intent, but we feel constrained to point out that in our view the language is not sufficiently explicit. In fact, the Secretary or Comptroller General, if they desire a complete survey of the field or a random sample, can easily comply with this provision by simply placing the name and address of each hospital on the envelope. Thus the term "specifically addressed" does not prevent the broad sampling which we understand is not intended.

The attached amendatory language attempts to make more specific the circumstances in which the investigatory powers of the bill could be invoked. It would limit the Secretary's request to transactions identified in the request. Moreover, it would make clear that requests made pursuant to the Section are not to be random samples or general surveys. Rather, the intent of the requests should be to address specific transactions to uncover specific instances of fraud. I respectfully ask that these Committees consider this language.

In addition, in the interest of strengthening the effectiveness of the bill, I would also recommend that the limited ownership and related information to be disclosed pursuant to Section 1124(a)(1)(C) which is currently limited to "5 per centum or more interests" be expanded by deleting the term "5 per centum or more."

The 5 percent limitation prevents the Secretary and the Comptroller General from obtaining information on ownership interests held by persons associated with the hospital if their ownership interest, individually, is less than 5 percent. Yet the ownership of even a small stock interest could create a psychological, if not a financial, conflict of interest. Indeed, this may be the very reason such ownership interests (particularly by physicians who could potentially use the hospital) are encouraged by the majority ownership.

I wish to make one further point to these Committees. Responsible nonprofit hospitals (which I believe represents by far the majority of all hospitals) have already adopted rules to deal with conflicts of interest. I have counseled hospitals for many years to disclose all conflicts of interest in their minutes and to have any interested Trustee leave the Board room during the discussion of the merits of the proposal and the vote. If Section 3 of the bill is amended as we have requested, I believe I can assure these Committees that our members will carry out the spirit as well as the letter of its provisions.

PROPOSED AMENDMENTS TO SECTION 3 OF H.R. 3

1. On page 6, lines 6-7, delete "request specifically addressed to," and add in lieu thereof "specific request directed individually."
2. On page 6, line 25, add between "transactions" and "between" the following: "identified in such request."
3. On page 7, line 2, insert the word "named" between "and" and "persons."
4. On page 8, line 1, delete "and."
5. On page 8, line 5, change the period to a semicolon.
6. At the end of page 8, line 5, add the following language: "and requests under paragraph (1) shall not be made of groups or selected samples of entities, but shall be made only of an individual entity with respect to a specified business transaction when the Secretary or the Comptroller General reasonably determines that the requested information relating to that particular entity is appropriate to carry out the purposes of this Act."

STATEMENT OF JACK A. MACDONALD, EXECUTIVE VICE PRESIDENT, NATIONAL COUNCIL OF HEALTH CARE SERVICES

Mr. Chairman Rostenkowski, Mr. Chairman Rogers, and the members of the Subcommittee the National Council of Health Care Services appreciates this opportunity to submit its views regarding H.R. 3. The National Council represents a select group of proprietary, multi-facility nursing home firms. Members of the National Council own and/or administer more than 75,000 beds in long term care facilities throughout the country. The National Council's members are also involved in other health-related services, such as hospitals, psychiatric facilities, rehabilitation centers and day care centers.

We would like to state at the outset that the National Council strongly supports the intent of H.R. 3 as reflected in the title of the bill, "Medicare-Medicaid Anti-Fraud and Abuse Amendments". The title delineates a problem area which has diminished the effectiveness of the Medicare and the Medicaid programs. A solution to this problem must be found before the adoption and implementation of any national health insurance program. If we do not solve it now, the financial damage will be magnified tenfold under a national health program.

During the Subcommittee's joint hearings, you have heard many witnesses speak about the amount of fraud and abuse and their opinions as to the reasons for these practices by providers under the Medicare and Medicaid programs. Most of the reasons which have been given can be traced tack to the diffusion and confusion in the administration of the Medicare and Medicaid programs. This state of affairs has resulted in a regulatory quagmire which has rendered the enforcement of standards nearly impossible. This in turn has directly led to the abuses and fraudulent practices noted by various critics of the health industry.

The administrative problems involve all segments of the programs, including eligibility criteria for beneficiaries, the delivery of services, the certification of providers, the payment system for services rendered under the programs, and the monitoring of the application of fraud standards. Improving the administration of the payment standards is particularly important in reducing the fraudulent and abusive practices of providers. We would submit that the fraud and abuse involved in the payment for services area can be directly traced historically to the failure to clearly delineate the level of service and responsibly define allowable costs by the agencies involved in administering the two programs. When this failure is combined with the lack in the past of concise cost reports and the failue to conduct audits, there is little wonder that we are having the problems with fraud and abuse in these programs.

We would agree with the statement by the Secretary of Health, Education and Welfare, Joseph A. Califano, Jr., in supporting H.R.3 when he stated that H.R. 3 would "strengthen the government's ability to detect and take action against fraudulent and abusive activities by program providers, suppliers, and individual practitioners . . . encourage more efficient and effective use of Federal and State funds."

However, the ultimate success of these provisions depends on improving the effectiveness of the administration of these programs, so that they can work.

For example, the disclosure reporting requirements contained in Section 3 of H.R.3 would clearly strengthen the Secretary's and the Comptroller General's authority to monitor and enforce the Medicare and Medicaid standards. It should be noted that a disclosure requirement has been required by statute since 1967 for Skilled Nursing Facilities and since 1972 for Intermediate Care Facilities. The same is true regarding penalties for defrauding the Medicare and Medicaid programs by "false reporting", "bribes", and "kickbacks". While these sections in H.R.3 may increase the Department of Health, Education and Welfare's ability to more effectively enforce its standards and thereby reduce the amount of fraud and abuse in the programs, they are not a substitute for increasing the effectiveness of the administration of the Medicare and Medicaid programs.

Mr. Chairman and Members of the Subcommittees, again as we stated earlier, the actual implementation of improvements in the administration of the Medicare and Medicaid programs falls under the authority of the Executive Branch of government. Secretary Califano's recently announced reorganizational efforts indicate that he has personally resolved to make the Department's administration of the programs more effective. We firmly support that intention.

However, H.R.3 in Section 5 requires that the Secretary report annually on the activities of PSROs. This requirement would provide the Subcommittee the ability to effectively exercise its oversight authority. We would simple recommend that a similar requirement be added to the issues identified in Sections 3 and 4.

The same facts apply to the area of payment for services. The authority is already available under the 1972 amendments to the Social Security Act (P. L. 92-603) to reform the payment systems for the two programs for nursing home services. Specific authority has existed since 1972 under both Sections

222 and 249 of P. L. 92–603, to reform the payment systems for nursing homes. We are particularly distressed at the fact that the Department of Health, Education and Welfare has failed to implement Section 249 in a responsible fashion as prescribed by statute.

That section was to have been effective July 1, 1976. However, the then Secretary of Health, Education and Welfare, F. David Mathews, attempted by regulation to postpone the statutory effective date until January 1, 1978. The reason for that postponement was stated by Mr. Mathews as being caused because of the "Department's delay in publishing final regulations".

This failure to responsibly implement Section 249 by publishing the regulations in a timely fashion so that they could be implemented, has contributed to the continuation of many of the practices which have been noted in testimony before these joint hearings. We would submit that, as the Deputy Comptroller General of the United States, Robert F. Keller, noted in a letter to the Chairman of the House Select Committee on Aging, the actions of the then Secretary "are contrary to the provisions of that statute" in attempting to relieve the States of meeting the requirements of Section 249. We would cite specifically the fact that the regulations implementing Section 249 (45 CFR 250.30) would

(a) Require the submission by skilled and intermediate nursing facilities of an annual uniform cost report.

(b) Require the conducting of on-site audits to verify the accuracy and reasonableness of costs provided on the cost report forms.

(c) Define allowable costs.

(d) Require that the State must take into account the actual cost of items defined as being allowable.

(e) Require that organizations related by common ownership be identified in terms of any transactions claimed for reimbursement by the Medicaid progarm.

(f) Encourage the States to develop prospective methods of payments.

I think that you will agree with us that the type of regulatory conditions set forth above, address the major problems raised during the Subcommittee's hearings. They should greatly reduce the amount of fraudulent practices occurring in the Medicare and Medicaid programs.

There is one additional area, however, that the regulations for Section 249 do not resolve. It is one which hasb een a large contributor to the problems which are occurring today in the long term care industry. We are referring specifically to the issue of a profit allowance for proprietary nursing facilities and a growth allowance for non-proprietary facilities.

Presently, the Medicare program allows only a return on owners' net equity for proprietary facilities and nothing for non-proprietaries.

The Medicaid program under the above cited regulation for Section 249 is silent in the actual regulation while attempting to restrict the methodology to that used by the Medicare program in the Preamble to the regulation. This has resulted in a great deal of confusion and numerous interpretations as to what is to be allowed, not to mention the question as to whether or not the Preamble has the same effect of law as the actual regulation.

The possible detrimental impact of the Medicaid program's adoption of the restricted concept will be far reaching since approximately 60% of the patients in nursing homes are Medicaid supported patients. It has, in short, the potential to do more damage to the quality of patient care than the fraudulent practices that we have experienced in the past under the programs.

While these herings are not addressing this issue, we would only point out that a situation is developing which could be much more devastating than the present subject matter. Again, it is the the result of ineffective administration and a failure to handle problems in a responsive and clear manner. Too many times in the past, factual evidence of an inconvenient nature has been conveniently ignored for dogmatic reasons.

While we have stated our support of the intent of H.R. 3, we would offer a word of caution. The prevalence of fraudulent and abusive practices by providers needs to be put into perspective before an entire industry is rendered useless as a result of over-zealous investigations. We would like to call three issues to the attention of the Subcommittee.

First, Mr. Chairman and Members of the Subcommittee, it is particularly disturbing to hear a Deputy Attorney General from the nation's most populous State remark that his agency, Office of Special State Prosecutor for Nursing

Homes, Health and Socail Services, has an intrinsic value because it has the potential for "making money". Are we to understand that the purpose of the Special State Prosecutor's Office in New York is "making money" for the State?

That is certainly a divergent purpose for a prosecutor's office from the traditional one of protecting the rights of the people of a State as a quasi judical office. In fact, we would submit that it is a twist to the concept of administering justice which the American people have traditionally rejected.

The dangers of applying such a concept have already been seen in New York State. Recently, Judge Patrick J. Cunningham dismissed an indictment against a nursing home administrator brought by the Office of the Special State Prosecutor. In dismissing the indictment, he state that "the Prosecutor's treatment of the issue of 'intent' and his attempt to give a 'rundown of cerain inferences that can be drawn from the evidence' can, at best, be characterized as manipulative, improper, and heavy-handed." The Judge went on to comment that "When over-zealous and ill-considered prosecution drives good, efficient nursing homes out of business, and oppresses well-meaning administrators, the people of the State are not well served."

We would submit that the establishment of any prosecutor's office on the premise that it is a revenue-producing agency will corrupt the basic principles of due process and the civil rights on which our judicial system is built in this country. In short, it will result in abuses of the type described in Judge Cunningham's decision. (A copy of the decision is attached to our statement.)

While we can not afford the present amount of fraudulent practices, neither can we afford the subversion of our system of justice in order to correct that problem. The former must be corrected without discarding the later.

Second, there needs to be established a clear distinction among fraudulent practices, abuses, and misrepresentations caused as a result of the lack of agreement on common definitions or interpretations of standards between providers and government agencies. Ths is an area which needs to be immediately addressed in the administration of the Medicaid and Medicare programs.

For example, there has not been a Federal definition as to the acceptable or expected quality levels of care in a skilled or intermediate care facility since the inception of the Medicare and Medicaid programs. Nor have we had a standard defining the acceptable level of service or allowable costs on a State or Federal level under the Medicaid program.

The Moreland Commission on Nursing Homes and Residentaial Facilities in the State of New York in its Report this failure to define quality of services expected from nursing facilities. The Commission reported that "nursing home regulators never developed explicit definitions of 'acceptable' care", nor have they "devised instruments to measure whether care rendered in homes is acceptable".

Yet, there are more than 520 detailed Federal Medicare and Medicaid requirements for a skilled nursing facility under the following general catgories:

Governing Body and Management—45 CFR 405.1121 [1]
Medical Direction—45 CFR 405.1122
Physician Services—45 CFR 405.1123
Nursing Services—45 CFR 405.1123
Dietetic Services—45 CFR 405.1125
Specialized Rehabilitative Services—45 CFR 405.1126
Pharmaceutical Services—45 CFR 405.1127
Laboratory and Radiological Services—45 CFR 405.1128
Dental Services—45 CFR 405.1129
Social Services—45 CFR 405.1130
Patient Activities—45 CFR 405.1131
Medical Record—45 CFR 405.1132
Transfer Agreement—45 CFR 405.1133
Physical Environment—45 CFR 405.1134
Infection Control—45 CFR 405.1135
Disaster Preparedness—45 CFR 405.1136
Utilization Review—45 CFR 405.1137

With this plethora of regulations, even without a definition of acceptable care, why should there be any problems with the quality of care in facilities? Again, the Moreland Commission identified the problem in its Report by stating that those charged with the responsibility of the Medicare and Medicaid programs "have not even taken the essential first steps, which are to determine what is important to rgulate in nursing homes, and how to measure what is important. Instead, regulation has been piled on regulation in bewildering detail, with little attempt made to determine which is essential and which superfluous."

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[1] Code of Federal Regulations citation

In the payment area, progress has not been any faster. It was not until last year that Federal audit standards were developed for detecting fraudulent financial practices under the Medicaid program. Today, this audit standard is being applied retroactively to the period before its existence when there were few if any standards, so is it any wonder that a number of highly questionable practices are being brought out into the open? Again, to quote Judge Cunningham, "Effectuation of the Medicaid rate formulas has been in a confused state and was only recently taken in hand and revised."

He went on to say in regard to New York's program that "the evidence is clear that everyone, including accountants and auditors, were uncertain . . . as to whether various items could properly be included in an HE–2P form (a New York State cost report form)".

Thus, we have had an extremely confusing situation where a lack of uniform interpretations of standards has resulted in a misrepresentation whose cumulative error may be of sizable proportions over a period of years. To define that type of error, however, as a dogmatically fraudulent or abusive practice is the close one's eyes to reality.

We would recommend that Section 4 of H.R. 3 be amended to specifically delineate between those misrepresentations which result from a lack of a common definition or interpretation of a standard from those in which there was the intent to obtain Medicaid or Medicare monies through factual misrepresentations. Unless this is done, a major injustice will be perpetrated against many health care providers who acted in good faith, but may have interpreted a standard differently from that of their State agency.

Third, there has recently been some hyping of budget figures and statistics to make them appear "massive". One recent example occurred in an official Department of Health, Education and Welfare document, entitled "Justifications of Appropriation Estimates for Committee on Appropriations: Fiscal Year 1978—Departmental Management'. It contained a passage which inferred that nursing homes were receiving $10 billion under Part A of the Medicare program. The fact of the matter is that nursing homes received in FY–1976 approximately $310 million out of an appropriated amount of $379 million. This particular misleading assertion was contined in a portion of the Department's Appropriation request for the Office of Investimations.

We would urge the Subcommittee to examine carefully the statistics presented to it as to their source and the purpose of which they are being presented. While even one dollar lost through fraud is one dollar too much, we would question the effectiveness of any effort which would spend one dollar to retrieve the original dollar. The more effective approach would be to effectively design the administration to avoid the loss in the first place, rather than retroactively retrieving it.

That brings us to prospective payment systems. This we would suggest offers the best method of eliminating the wastes and manipulative practices of the past, as well as controlling the cost of health care. As noted, one of the inefficiencies of many of the present payment systems is that final determinations of payment are not made until long after the service is rendered on the patient. Frequently, the amount of final payment is more a result of the negotiating and accounting ability of management that it is of their health care administrative ability.

The retrospective cost reimbursement process also contains little incentive for management to expend any special effort to reduce or contain costs. This lack of concern for cost, has led to a myriad of regulations designated to cover what is a conceptual flow in the system. This has without question resulted in uncontrolled increases of costs.

The provider has been effectively relieved of any responsibility for financial of budget planning since any plans have been adversely affected by extensive retroactive adjustments.

The prospective development of rates would allow management to know the amount of the payment as well as how it will be made in advance of the delivery of the service, thus creating considerable pressure for effective management. Also, under a prospective rate system, the provider who is planning an expansion of services can more effectively review the feasibility of that expansion.

In view of the preceding discussion, it is understandable, but not excusable, to see why we are having the problems with fraudulent and abusive practices that we are in the two programs. We have tried to suggest some possible solutions and hope that they will be considered during the deliberations of the Subcommittees of H.R. 3 and other Medicare and Medicaid legislation.

In conclusion, fraudulent or abusive practices must be eradicated from the Medicare and Medicaid programs, H.R. 3 should constructively assist in that effort and we support it in that intention.

We would only caution against adding additional requirements to H.R. 3 at this time. The new Secretary of Health, Education and Welfare, Joseph A. Califano, Jr., should be given the opportunity to implement and evaluate the new Office of the Inspector General and in the case of nursing facilities, the new regulations regarding payment for services under the Medicaid program. This is particularly true in regard to the latter in terms of adding the requirement of a national uniform accounting system.

We would like to express our appreciation to the Chairlmen and the Members of the Subcommittees for this opportunity to submit our comments on H.R. 3.

State of New York
County Court, County of Onondaga
Indictment No. 76–257–1
Index No. 75/838

THE PEOPLE OF THE STATE OF NEW YORK
v.
JOSEPH SHABEN

Appearances: Charles J. Hynes, Esq., Deputy Attorney General, Robert E. Wildridge, Esq. of counsel, Special Assistant Attorney General, Attorney for the People; Driscoll, Mathews, Gingold & Cass Daniel F. Mathews, Jr. Esq. of counsel, Attorney for the Defendant.

CUNNINGHAM, J.

DECISION/ORDER

Defendant is the administrator of a small nursing home. Based upon alleged misrepresentations contained in HE–27 forms filed on behalf of the nursing home for the years 1969 through 1974 he has been charged with five counts of Grand Larceny in the Second Degree, one count of attempted grand larceny in the third degree, four counts of offering a false instrument for filing in the first degree, and four counts of falsifying business records in the first degree. Defendant seeks dismissal of the indictment herein on ground of insufficient evidence before the Grand Jury, and defective Grand Jury proceedings.

The People concurred in Defendant's companion motion for inspection of the Grand Jury minutes in this case, to the extent that such inspection be made pursuant to Section 210.30 of the Criminal Procedure Law. Accordingly, this Court has read the transcript of proceedings before the Grand Jury, and has thereby determined that dismissal of the indictment herein is required on several grounds.

First, the indictment must be dismissed on the basis that the Grand Jury proceedings were defective within the meaning of Section 210.35 (5) of the Criminal Procedure Law. That is, errors made regarding the rules of evidence contained in Section 190.30 of the Criminal Procedure Law, and the duties of the presiding prosecutor as set forth in Section 190.25, had a cumulative effect which was extremely projudicial to the Defendant, and denied him due process of law. The more flagrant of those errors include:

1. Distribution of a chart, Exhibit #109, to each Grand Juror for use in his deliberations, which chart purported to summarize the various misrepresentations made by the Defendant. The chart contained columns, two of which were entitled "amount fraudulently overstated" and "amount of larcency or attempted larceny". The word "alleged" appears nowhere in that chart, and as set forth it conveyed the inescapable conclusion of guilt to each juror. Whatever proper

instructions may have been given orally to the jurors regarding their role as fact-finders, it was that written, highly prejudicial, chart which each juror had before him during crucial deliberations as to the guilt or innocence of the Defendant.

2. Improper and erroneous legal instructions were given by the Special Prosecutor during the course of legal instructions as to the various elements comprising the crimes charged. For instance, directly after reading the definition of intent, the Prosecutor read Section 15.20 of the Penal Law concerning "mistake of fact" and mistake of law". Inclusion of that section was not appropriate, and without further explanation or elaboration it could easily have confused the Grand Jurors, and may well have ruled out in their minds the need for further consideration of the element of intent, or guilty knowledge. Clearly, the Grand jurors were affected by the section, as they asked to have it re-read. In a case where knowing misrepresentation and intent to defraud are crucial, casual exposure of Grand Jurors to Section 15.20 of the Penal Law could prevent a fair consideration of the case.

At another point, the Prosecutor discussed an inference as to intent which might prove favorable to the accused, then went on to say:

"Now, you are free to draw such an inference . . . but you need not draw that inference as you need not draw any inference from the evidence which fails to satisfy you it is the only inference that can be drawn."

This Court has never before seen the law regarding circumstantial evidence twisted so as to require that no hypothesis other than that of innocence flow from the facts. On the other hand, the jurors were told they could make various obscure and tenuous inferences of guilty intent, all without a reminder that when such evidence points to guilt it should be the only inference that could reasonably be drawn from the facts.

3. Heresay, suppositions, innuendo and prejudicial discourses were permitted throughout the testimony before the Grand Jury. Little attempt was made to limit irrelevant and prejudicial questions and answers as found, for instance, in the testimony of Jo Ann Bock and Frank Blankley. Furthermore, various accountants for the nursing home, as well as auditors, were encouraged to "assume" they must have talked to Mr. Shabe about certain items. Since accountants in such cases conceivably be implicated themselves, such assumptions were particularly incompetent and self-serving. One witness, Robert Crelot, was even recalled by the Prosecutor in order that he might state for the record that he had had an opportunity to think about his testimony, had changed his recollection after a conference with the Prosecutor, and that "the only source for any oral information * * * received with respect to insurance was Mr. Shaben". In his summation, the Prosecutor referred to this set of leading questions and answers, stating:

"It is my recollection from the testimony of Robert Crelot . . . that the only person to whom he talked about insurance expense for the nursing home during the course of his audit was Joseph Shaben. One can infer then that he had a conversation with Shaben in which Mr. Shaben identified such insurance to Mr. Crelot without informing Crelot of the full, true and correct nature of the annuity contracts about which Mr. Crelot was asking."

Quite an inference! It should be noted that none of the various accountants who filled out the HE-2P forms through the years could recall a specific occasion on which Shaben definitely explained any particular expense to them, except insofar as he identified certain personal insurance as not being nursing-home related.

4. Failure to clarify the factual basis for the offenses charged permeated the entire proceedings. It is clear that right through the final days of testimony serious misunderstandings persisted which were potentially prejudicial to the defendant. One juror asked on the last day:

"How, in turn, would he (Shaben) come about getting this money, if it was made out to the nursing home? . . .

Who speaks for the patients and families who lost this money illegally? Shouldn't we bring this to someone's attention?"

—June 2, 1976 pp. 103, 104–5

Earlier, one juror spoke of Mrs. Shaben receiving direct reimbursement for her salary. There seemed to be no general understanding that itm for item reimbursement was not involved here, but instead a procedure for setting rates of payments to nursing homes. Furthermore, emphasis was placed upon issues never intended to be included in the final charges against the defendant. At times it appeared that the Grand Jury was being used more as an investigatory tool than as an accusing body. The result was a rambling presentation covering a two-month period in which areas of possible wrong-doing were explored without a clear-out idea of where matters were heading. A great deal was made, for instance, of Mr. Shaben's maintenance salary, and of salary ceilings, and one witness was even asked whether groceries were ever taken by Shaben from the nursing home for use in his personal kitchen. The answer was 'no". Some irrelevant items were actually included in the final chart (Exhibit 109) under "amount fraudulently overstated" with the dubious footnote explanation that the "figure in placed here for convenience only". It is very possible that the Grand Jurors were never able to sort out alleged criminal acts from the irrelevancies to which they were exposed, and that in such a highly complex case their misunderstandings tipped the scales against the Defendant.

Finally, it should be noted that the atmosphere of the proceedings was charged with juror hostility. One witness who is employed by the nursing home was allowed to be badgered mercilessly by the jurors, and was later sent a letter by the Special Prosecutor informing her that she had been accused by jurors of stealing exhibits from the Grand Jury room. She suffered a heart attack soon after, which prompted a letter of apology from the Prosecutor in which he admitted that the "lost" exhibits had been found. A lawyer witness for the nursing home was similarly harrassed by jurrors, and another witness was asked whether Shaben looked "sneaky". Several jurors voluntered the possibility of crimes never contemplated by the Prosecutor, and one wondered why they couldn't charge grand larceny in the first degree. Such hostility, in conjunction with all the other errors heretofore discussed, had the cumulative effect of denying the defendant due process of law. A similar conclusion was reached in the case of *People v. Percy* 74 Misc 2d 522 for many of the same reasons. When Grand Jury proceedings are handled in the manner described above, the presiding attorney serves, in effect, as accuser, prosecutor and judge rather than as legal advisor. This Court will not tolerate such abuse of the Grand Jury system within its jurisdiction.

As a separate basis for dismissal, this Court finds that the evidence before the Grand Jury was not sufficient to support the crimes charged, nor any lesser included offense. Misrepresentation is an essential element of each crime charged, yet every entry made by Mr. Shaben on the check stubs used in filling out HE-2P forms was a true and accurate description of the expense involved, and to whom it was paid. Problems arose only with regard to specificity, and interpretations by the state as to just what were reimbursable expenses. There is not competent evidence before the Grand Jury to indicate that Mr. Shaben misled anyone as to the precise nature of the expenses. Instead, there is evidence that he did on occasion identify certain insurance expenses as personal and not nursing home-related. Arguably every expense involved in this case was nursing home-related, and could be included on an HE-2P form subject only to interpretation. Therefore, criminal intent could not be inferred from the acts of the Defendant, as is often the case with other types of crimes. On the contrary, there was evidence before the Grand Jury that no definitive rules and regulations existed to help guide nursing homes, that the coding charts used by Mr. Shaben in filling out check stubs were provided to him by his accounting firm, and that the firm flatly refused his attempts to revise and "complicate" those codes in line with advice he had received from his nursing home association.

There was simply no competent evidence before the Grand Jury which, if accepted as true, would establish the elements of misrepresentation, guilty knowledge or intent to defraud. Applying the accepted test, the evidence, if unexplained and uncontradicted, would not support a verdict of guilty after trial. *People v. Dunleavy*, 41 AD 2d 717, *Aff'd*, 33 N.Y. 2d 573.

Finally, in addition to the aforementioned, this Court is moved to dismiss the indictment herein the interest of justice. It is felt that crimnal charges are inappropriate in this case, and that prosecution of the Defendant would constitute a grave injustice. This is not a case where mink coats or swimming pools were claimed as nursing home expenses. As stated above, all expenses involved were arguably nursing home-related, and were found to be "misrepresnted" only in light of certain interpretations made by the state as to what was and what was not an allowable expense. Effectuation of the medicaid rate formulas has been in a confused state, and was only recently taken in hand and revised.

The evidence is clear that everyone, including accountants and auditors, were uncertain throughout the time period covered by this indictment as to whether various items involved could properly be included in an HE-2P form. Lack of communciation seems to be the problem here, and the government must shoulder its share of the blame for that state of affairs.

Also, we are dealing here with a process wherein exact information is not required. Public Health Law, Section 2807 (3), requires only that rates of payment for health related services be "reasonably related to the efficient production of such service". The nursing home involved in this case is considered by many doctors and others to be superlative in terms of patient care and concern. It has accomplished this while operating at the third lowest rate of medicaid reimbursement in the county. Maple Lawn has consistently received less than half as much money per medicaid patient as have most nursing homes in the area. In spite of this, the home has born the additional financial burden of paying back to the state all of the money received as a result of the alleged misrepresentations upon which these criminal charges are based. This is significant in light of the fact that Mr. Shaben's only purported "crime" was to affect that very low rate of payment for nursing home care at Maple Lawn. He is not the owner of the home, and it is not claimed that he acted for personal gain.

For the above reasons, then, this Court finds that prosecution of the Defendant upon this indictment would constitute an injustice, and therefore exercises its discretion to dismiss the indictment in the interest of justice.

Parenthetically, it should be noted that the Special Prosecutor's Office has, in many instances, uncovered and prevented true abuses of the medicaid system, and has thereby served the people of New York State well. Furthermore, the special prosecutor in charge of this case is known to the court as an able and respected attorney, with outstanding credentials. Nevertheless, we can only conclude that in cases such as this the power of the Special Prosecutor's Office is misused. The facts upon which this indictment was based simply do not justify the inordinate amount of time and money expended in its pursuit. When overzealous and ill-considered prosecution drives good, efficient nursing homes out of business, and oppresses well-meaning administrators, the people of the State are not well-served. Perhaps the State should adopt a policy of cooperation and education in these marginal cases, rather than one of retribution, in the hopes of creating a more effective medicaid payment system in the future.

Defendant's motion to dismiss the indictment herein is granted on the grounds stated.

It is so Ordered.

PATRICK J. CUNNINGHAM,
County Court Judge.

Dated: Syracuse, N. Y., December 30, 1976.

NEW YORK COUNTY HEALTH SERVICES REVIEW ORGANIZATION,
New York, N. Y., March 7, 1977.

MR. JOHN MARTIN, JR.,
Chief Counsel,
Ways and Means Committee,
Longworth House Office,
Washington, D.C.

DEAR MR. MARTIN: New York County Health Services Review Organization, Inc. (NYCHSRO), the PSRO for Area XI of New York State, representing approximately 12,000 physicians and covering 37 short stay general hospitals which account for 250,000 federal admissions each year under the Medicare and Medicaid programs, is fully in support of the provision in H.R. 3 which allows PSROs to furnish appropriate data to state and federal agencies investigating fraud and abuse. In our judgement, for any such provision to be effective, and for the full potential of PSROs to be realized, the phrase "appropriate data" must be broadly defined and those to whom PSRO may furnish such data must be expanded.

The delay in the development of confidentiality and sanction regulations, coupled with the strict and limiting interpretation of the interim confidentiality provisions by the General Counsel of the Bureau of Quality Assurance (BQA) has severely hampered the potential role of PSROs in monitoring professional conduct. Therefore, NYCHSRO recommends that the legislation be revised to explicitly state that "appropriate data" be defined as including, inter alia, information regarding patterns of medical practice; peer review findings with respect to quality of care; PSRO recommendations regarding a physician's continued eligibility to participate in the Medicare and Medicaid programs; and recommendations regarding licensure based on peer review findings.

The list of those agencies to which PSROs may be allowed to furnish such information should likewise be expanded to include, in addition to state and federal agencies, local agencies, including among others, departments of health and social services, medical society committees, hospital utlization review committees, the state agency responsible for administration of the Medicaid program (Title XIX), the federal agency responsible for administration of the Medicare program (Title XVIII) and professional licensing boards.

PSROs are in a unique position in that they have access to information, which, if properly used, could be instrumental: (1) reducing unnecessary utilization, and (2) assuring that care provided meets professional quality standards. If the services rendered to patients in a PSRO area are to be improved, and if the medical profession is to be capable of regulating its own members, the data which PSROs generate must be utilized properly, as determined by the PSRO, within statutory limits and/or regulatory guidelines.

While NYCHSRO has expressed opposition to the release of certain information, such as identifiable hospital data, except under certain circumstance and as agreed to by the PSRO and the planning agency, NYCHSRO firmly believes that confidentiality guidelines pertaining to individual practitioners should not be used to cover-up or conceal inappropriate or substandard care, medical malpractice or any form of professional misconduct.

Sincerely,

Eleanore Rothenberg, Ph. D.,
Executive Director.
Roger W. Steinhardt, M.D.,
Medical Director.
Irwin J. Cohen, M.D.,
Chairman, Board of Directors.

Statement of the New York State Association of Nurse Anesthetists, Inc., Submitted by Edward H. Triebel, President

The New York State Association of Nurse Anesthetists, Inc. is an organization made up of approximately 780 active, practicing, Certified Registered Nurse Anesthetists in the state of New York. This Association is greatly concerned about the rise in medical care prices and is aware of the Committee's desire to correct some of the abuses which have grown under the policies, rules and regulations of the Medicare—Medicaid programs.

Nurse anesthetists are amajority group in delivering anesthesia services. There are currently over 14,000 Certified Registered Nurse Anesthetists (CRNAs) providing anesthesia care in this country. This represents the largest percentage of anesthesia service provided according to a study in 1974 (48.5%). The anesthesiologists (including both Board Certified and non-Board Certified) rendered approximately 38.3% of the anesthesia care according to that study, 9.7% was administered by physicians other than anesthesiologists, and 3.5% by Registered Nurses who are not CRNAs. The services rendered by CRNAs in this country have not been appropriately recognized within the present federal, state, and local health care programs, and therefore, we believe the lack of recognition of these services has contributed to some of the abuses which have developed since the inception of the Medicare—Medicaid laws.

The laws and associated administrative rules and regulations deal with the CRNA as a "legal nonperson". Reimbursement for their services is in a rather elliptical fashion, not commensurate with education, legal and professional responsibilities. Federal policies relative to reimbursement under the Medicare—Medicaid program of non-physician personnel has permitted only indirect billing and indirect reimbursement for the qualified nurse anesthetist. A nurse anesthetist's service under Part B, according to a Federal Directive, is covered as an incident to a physician's professional services, and only when under the direct personal and continuous supervision of the physician. Therefore, anesthesiologists, surgeons, obstetricians and other physicians have had an exclusive privilege to bill for anesthesia services under Medicare—Medicaid policy. A qualified nurse anesthetist delivering direct anesthesia care is required to make "arrangements" with physicians to bill on a fee-for-service basis for services rendered. This has, we believe, fostered unfair billing practices and placed the nurse anesthetists in a vulnerable position by obligating inclusion of their bills with that of a physician. Some members of this Association have consistently run into difficulty attempting to work out equitable financial arrangements with patients, hospitals, and physicians when he or she is required to provide direct anesthesia care services to individuals eligible for Medicare—Medicaid benefits. Consequently, abuses have developed within the reimbursement arrangements for anesthesia services under federal health care programs. Part of this we attribute to the hodge-podge philosophy of health care reimbursement under program directives and complex policies.

The basis for federal, state, and local reimbursement policies for anesthesia services, we believe, stems from the philosophy and concepts that nurse anesthetists cannot and should not deliver anesthesia care without the direct supervision of a physician; in particular, an anesthesiologist. One may go on to say that the quality of service is perhaps best measured by the levels of skills of the performing of the anesthesia service. We believe there is a need for a thorough study of quality of anesthesia services in this country and we hope that such a study will be undertaken in the near future. However, the present fact of the matter is that qualified nurse anesthetists do supply direct anesthesia care on an independent basis, and in an unsupervised capacity. We wish to stress that professional services such as anesthesia care may be construed as nursing practice when provided by duly specialized nursing practitioners and as medical practice when provided by duly prepared physicians. In a collaborative arrangement both disciplines can produce expanded high-quality care at a more reasonable public cost. The professional skills and responsibilities of CRNAs should, however, be recognized within federal, state, and local health care laws, policies, rules and regulations. We believe that the inequities in the present reimbursement procedures for anesthesia services have had profound effects on the practice of many CRNAs, and has led to an economic discrimination against not only the consumer, but the qualified nurse anesthetist as well.

The basis for the reimbursement philosophy of nurse and physician anesthetist providing direct care is badly in need of revision. Some CRNAs are presently doing Medicare—Medicaid cases without being reimbursed for their services! The evolution of the payment scheme under state and federal medical assistance programs has frustrated nurses and physicians trying to meet their obligation to the public. Many such situations place the CRNA and physician in a vulnerable position ethically, legally, morally and financially.

Physicians and nurse anesthetist can collaborate effectively and fairly if the law-makers specifically identify the nurse statutorily, thereby encouraging full utilization of qualified nurse anestheticsts' services. Abuses under Medicare—Medicaid programs can be corrected in part by establishing reimbursement protocol which assures fair and just distribution of these health care funds for anesthesia services.

The New York State Association of Nurse Anesthetists, Inc. therefore recommends:

I. That Certified Registered Nurse Anesthetics (CRNAs) be reimbursed for their direct professional services on a nationally devised fee schedule with payments made directly to the anesthetist, to the group with which the anesthetist practices, or through the hospital in which the service is provided.

II. That protocol be established to insure that no provided of direct anesthesia care can claim to be involved in the complete management of two operative cases simultaneously.

III. That the rank discrimination and inequities in reimbursement, as between physicians providing anesthesia services and Certified Registered Nurse Anesthetists providing such services, that presently exist in Medicare and Medicaid laws be removed or amended so as to recognize the services of the Certified Registered Nurse Anesthetist.

STATEMENT OF PHILIP L. TOIA, COMMISSIONER OF THE NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

Thank you for the opportunity to submit written testimony offering the view of New York State regarding the "Medicare-Medicaid Anti-Fraud and Abuse Amendments," S. 143 and H.R. 3.

Medicaid fraud and abuse has been a serious problem in New York State as well as in the entire nation. In New York, health care is a 15 billion dollar enterprise, and the State is directly or indirectly involved in some way in almost all areas of health care. Medicaid alone represents a $3 billion burden on our taxpayers.

No one doubts the need to reform the administration of the Medicare and Medicaid programs. But we must insure that legislation goes beyond attacking the symptoms of a poorly planned program to deal with the more basic issues of program reform.

Without enlightened fiscal responsibility, elimination of fragmented administrative responsibilities, and reform of the programs' financing, there is little hope for truly improving this nation's health care delivery system for our poor and elderly.

We feel that there is an important distinction between fraud and abuse. The subject bill addresses criminal abuses (fraud) but does not defined or establish penalities for non-criminal abuses and unacceptable practices which constitute the greater problem measured in terms of dollars lost. Such non-criminal abuses included conduct which fails to meet standards of good professional medical care and treatment, disregards established policies, standards, fees, and procedures, represents the provision of unnecessary, inadequate, excessive, or poor quality care and services or is a threat to public order to achieve significant Medicaid reform.

In New York State, a number of measures have been taken or proposed to combat fraud and abuse in the Medicaid system.

First, a special prosecutor for nursing homes has been appointed to investigate the allegations of illegal activities by nursing home operators. This investigation has proceeded effectively, resulting in numerous indictments and convictions. Over $1 million in restitution has already been obtained and it is estimated that potentially nearly $50 million in restriction will be collected. Cooperation between the State Department of Social Services and the Special Prosecutor is helping to further identify possible instances of fraud and abuse.

In order to correct abuses prevailing in Medicaid Mills, and to continue the State's careful scrutiny of the costs and services of the Medicaid program, New York is continuing development and implementation of a Medicaid Management and Information System (MMIS). This system will greatly streamline Medicaid administration and will reduce ineligibility and overpayments.

As an interim step pending full MMIS implementation, a provider profile system to identify and track unusual provider billing practices is in place for New York City. In cooperation with local prosecutors in New York, we have used this system to uncover fraudulent and abusive practices in ambulatory care and seek restitution of public funds. During the past ten weeks, the State has billed providers for improper payments amounting to $3 million. It is expected that this effort will result in the collection of $20 million this year.

Governor Carey, in his recent State of the Health Message, has proposed a single Medicaid fraud and abuse unit at the State level within the Department of Social Services. The unit will contract with the Health Department for necessary expert services. The unit is designed:

(1) To identify fraudulent and abusive actions of Medicaid providers;

(2) To recover to the maximum extent possible incorrect or inappropriate payments made to providers;

(3) To establish a strong deterrent against future fraudulent and abusive practices of providers; and

(4) To identify and refer to licensure action any providers suspected of engaging in professional misconduct.

To accomplish these objectives the fraud and abuse unit will perform investigations and reviews and prepare litigation.

We point out the actions taken by New York State to demonstrate the need for a multi-phased attack on the problems of fraud and abuse in the Medicaid system. Many of the provisions in the proposed legislation will serve to complement and strengthen these anti-fraud and abuse efforts. It must be stressed, however, that real reform depend upon the elimination of administrative weaknesses in the Medicaid system which invite abuse, such as lack of clear management accountability because of fragmented administration and multiple sources of funding, complex regulations, long delays in payment, and absence of copayments so that recipients do not have a financial stake in the volume of care rendered. New York looks forward to the opportunity to present more detailed comments on Medicaid reform later this year in connection with the proposed "Medicare-Medicaid Administrative Reimbursement Reform Act."

Our comments on the specific provisions of H.R. 3 and S. 143 are as follows:

SECTION 2. PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS OF CLAIMS FOR SERVICES

The proposed amendments are acceptable since they clarify federal policies with regard to approved and unapproved assignments. The exceptions are reasonable in terms of existing practices in the health care area and the need to prohibit assignments in circumstances involving potentially fraudulent or abusive practices. A flexible penalty, up to disallowance of the entire payment, at the discretion of the State, should be considered.

SECTION 3. DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

The underlying thrust of the proposed full disclosure requirements is both laudable and warranted. The right to request and obtain information concerning financial inter-relations of providers, suppliers and individuals is an important and necessary tool in investigating fraud and abuse of the Medicaid and Medicare programs. Several specific areas of possible improvement in the proposed amendment include:

A. No provision is made for State participation in obtaining full disclosure from providers, suppliers and others. For those programs in which States have substantial involvement and responsibility (i.e. Title XIX) the opportunity to obtain such disclosure is vital. Proposed § 1124 should be changed accordingly.

B. Access to the actual books and records of providers and suppliers is restricted to a limited number entitles—independent pharmacies, laboratories, etc. Such access to actual books and records—on site—should be provided for all providers and suppliers of services and items under Title V, XVIII and XIX.

C. Questions have been raised concerning whether the 5% or greater limitation on an interest (in an entity, lease, mortgage, etc.) that must be disclosed is warranted. It is often true that interests smaller than 5% are significant for investigative purposes. This matter should be more carefully considered.

D. Those provisions of this bill which define "shared health facilities" and which treat a group of physicians and non-medical persons together as a single entity for reporting purposes raise more questions than they resolve. To the extent that the intended purpose of these parts of the bill is to obtain information from the non-medical persons involved in Medicaid Mill operations, the same results can be achieved without establishing a specific definition of shared health facilities. In addition to our reservations concerning the need for a definition, we find certain weakness in the definition itself. If you find that a definition of shared health facilities is absolutely necessary, however, we will be happy to work with congressional members and staff to develop a more satisfactory definition.

E. The sanction of cutting off Title V, XVIII, and XIX funds if a facility fails to comply with the new disclosure requirements set forth in § 1124 would presently be unenforceable against Shared Health Facilities in New York State. This is because SHFs, as entities, do not directly receive Medicaid or Medicare payments. We therefore propose that § 1124(b) be revised to provide for the imposition of a financial penalty against owners and/or operators of shared health facilities who fail to comply with the disclosure requirements.

SECTION 4. PENALTIES FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

Although effective preventive measures are preferable to the imposition of criminal penalties after the fact, the proposed changes in applicable penalties are desirable. White collar crime, such as Medicare and Medicaid fraud and abuse, has, too long, been treated lightly by the American legal system. Increasing public awareness of the harm, to the receipients of public assistance as well as to the general welfare, caused by such crimes is reflected in the proposed amendments.

However, the Medicare and Medicaid penalty sections should be amended to provide authority for the imposition of *both* a fine and a prison sentence. Such treatment of certain offenders is desirable, particularly in preventing fraud and abuse by others.

SECTION 5. AMENDMENTS RELATED TO PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

This section appears only in the House version of the bill. It is our position that as long as the State maintains responsibility for a substantial portion of Medicaid funding it should retain the right to conduct independent reviews with respect to the quality and medical necessity of services rendered. We are therefore strongly opposed to the proposed amendment to Section 1158.

Furthermore, we are concerned that case by case PSRO review would not be a cost-effective strategy for detecting fraud and abuse in the areas of ambulatory care. A preferable approach would be to use the MMIS capability of profiling providers and recipients to flag exceptional cases for further investigation. A major subsystem of MMIS, the Surveillance and Utilization Review Subsystem, is specifically designed for this purpose. A State utilization review unit would then be responsible for reviewing exceptions and taking appropriate follow-up actions. In the case where a capable PSRO exists, the State should have the option of contracting with the local PSRO to perform this review function.

SECTION 6. ISSUANCE OF SUBPOENAS BY COMPTROLLER GENERAL

The right to issue subpoenas, in connection with the investigation of Medicaid fraud and abuse, should be extended to the heads of State agencies as well. At present, the New York State Commissioner of Social Services does have the power to issue similar subpoenas under the Social Services Law (34.5). Such State administrative subpoenas may be used to compel both testimony and the production of documents. They presently are being used fruitfully in our fraud and abuse effort. However, it would be most useful if the State Commissioner alternatively could avail himself of a federally authorized subpoena, serveable by registered or certified mail and enforceable in Federal Court.

Several other changes in the proposed amendment are warranted: the opportunity for properly authorized subordinates of the Comptroller General to issue such subpoenas and the ability to request (clarifying) testimony in addition to the actual production of documents.

SECTION 7. SUSPENSION OF PRACTITIONERS CONVICTED OF MEDICARE OR MEDICAID RELATED CRIMES

We support the provision for automatic, mandatory suspension of practitioners convicted of program-related crimes. The state's discretion to determine the length of the suspension should be sufficient to address situations where a critical shortage of medical providers would result from prolonged suspension. We recommend, however, that it be added that these penalties are not intended to be in lieu of any other penalties as provided under state and federal law. Furthermore, the penalties described in this section are not to be construed so as to prevent a state from taking action against a provider for reasons other than conviction of a crime.

SECTION 8. DISCLOSURE BY PROVIDERS OF OWNERS CONVICTED OF CERTAIN OFFENSES

We support this provision.

SECTION 9. FEDERAL ACCESS TO RECORDS

This amendment to permit federal access to Medicaid records in circumstances where State agencies have access is appropriate. Close cooperation between federal and state governments should avoid onerous duplicative requests for information. However, Section 1902(a)(3)(B) should be further amended to provide access, under reasonable conditions, for federal and state investigators, to provider files in the location where they are customarily maintained. Such a requirement would aid greatly in the fraud and abuse investigations and would also serve to prevent future abuses.

SECTION 10. CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS FOR MEDICAID PROGRAMS

This amendment would permit States to provide the required MMIS notice to a sample group of service recipients, instead of the whole population thereof. Support of this amendment is warranted. It would help eliminate unnecessary expense and effort in implementing the MMIS system. A sample mailing is completely adequate for the MMIS system to function effectively in discovering and preventing abuses.

SECTION 11. MEDICAID AS PAYOR OF LAST RESORT

A state that chooses to make services available to a group of people that do not qualify for Medicaid should not be penalized with a loss of Medicaid funds for the group which does qualify. We therefore suggest that the exceptions noted in paragraph (38) be changed to include "(other than a member of the individual's family or public agency.)"

In addition to our above comments on the specific provisions of the bill, we would strongly recommend that the bill be amended to:

1. Require the Secretary to maintain a central registry and data exchange on all providers convicted of Medicaid or Medicare-related criminal offenses and to notify all states of such convictions and related suspensions.
2. Require that whenever the Secretary issues any orders pursuant to the provisions of Sections 3(a), 6, or 7 of the proposed bill, that he shall submit a notice of such order to the single state agency of each state.
3. Provide for the authority for termination or suspension of providers from participation in Title XVIII and from participation in all states' Title XIX and Title V programs when any state has made a determination to terminate or suspend a provider from participation in Medicaid for practices which constitute non-criminal abuses and unacceptable practices.
4. Require that when seeking restitution for improper medicaid payments, the federal government seek restitution of all expended public funds, including the federal, state and local shares.

The portion of H.R. 3 that increases the penalties for defrauding the Medicare and Medicaid programs does not address this important need in coordinating state and federal anti-fraud and abuse efforts. At present, there is no explicit authority for the U.S. Attorney to obtain restitution of the state and local portions of Medicaid payments at the same time as the federal portion is sought.

This had led to an unnecessary and wasteful duplication of efforts on the state and federal levels to obtain restitution of portions of what was, to the service provider, one payment. In certain cases, obtaining restitution of the federal portion, together with the application of fines and penalties, has exhausted the service provider's fiscal assets and thereby prevented restitution of the state and local portions.

As present, when the states or localities obtain restitution, it is their practice and obligation to obtain restitution of the full Medicaid poyments, including the federal, state and local shares. The federal government, including the U.S. Attorney, should be under a similar obligation.

The U.S. Attorney General and his subordinates, the U.S. Attorneys, have concluded that the federal False Claims Act authorizes only a suit for restitution of the federal portion of a fraudulently obtained Medicaid payment. The Act should be amended to permit the federal government to require restitution of the full Medicaid payments prior to the imposition of any fines or other penalties. These requirements should also apply to out-of-court settlements of such claims against Medicaid providers.

An alternative approach would be to specifically authorize states to join as parties to any federal litigation and/or negotiations for restitution of Medicaid payments. This approach is less desirable, however, since it would require unnecessary and redundant actions by both the federal and state governments.

In conclusion, I would like to state New York's total commitment and support for constructive reforms in the area of Medicaid fraud and abuse. We feel these reforms are obviously important, necessary and achievable. Thank you once again for the opportunity to comment on this bill. We would be most happy to provide any additional information which you think may be helpful.

The following letter was received in response to the press release announcing the hearing:

UNION OF AMERICAN PHYSICIANS,
San Francisco, Calif., February 14, 1977.

Hon. DAN ROSTENKOWSKI,
Chairman,
Subcommittee on Health,
Committee on Ways and Means
Longworth House Office Bldg.,
Washington, D.C.

DEAR CONGRESSMAN ROSTENKOWSKI: We are in receipt of your communication requesting the testimony of the Union of American Physicians in the matter of Medicare-Medicaid Anti-Fraud and Abuse Amendments.

Previous commitments make it impossible for us to appear personally at these hearings scheduled for March 3 and 7, 1977.

We wish you to know of our support for any reasonable measure that would curtail improper practices by the small minority of health providers who have reflected so unfavorably on our profession.

Despite the seriousness of these abuses, and the pressing need that they be stopped, however, we retain grave reservations that methods may be adopted which will in effect punish the innocent along with the guilty.

The presumption that the overwhelming majority of the American medical profession remains innocent of these heinous practices must provide the foundation on which you build any legislative approach to this problem. The imposition of burdensome paperwork, the taking of honesty oaths, and similar requirements could well create a climate in which physicians would be deprived of their pride and satisfaction in participating in government health programs.

We are all aware that a program of nationalized health insurance lies in the near future. The success of any such program must be dependent on the cooperation of the medical profession. If, through prima facie assumptions of culpability of doctors, this spirit of cooperation is destroyed, the success of all future health care programs could be placed in jeopardy. Will you please include this statement in the official record as representing our testimony.

Thank you for the opportunity to express the opinion of the UAP in this matter.

Respectfully,

SANFORD A. MARCUS, M.D.,
President.

UNITED SOCIETIES OF PHYSIOTHERAPISTS INC.,
March 3, 1977.

Hon. DANIEL ROSTENKOWSKI,
Chairman,
Subcommittee on Health,
Committee on Ways and Means
Longworth House Office Bldg.
Washington, D.C.

DEAR HON. ROSTENKOWSKI: The United Societies of Physiotherapists, Inc. wishes to thank the members of the Subcommittee on Health for this opportunity to present testimony on the subject of Medicare-Medicaid Anti-Fraud and Abuse Amendments, H.R. 3. The following organizations join with the United Societies of Physiotherapists, Inc. in this presentation:

Council of Licensed Physiotherapists of New York State, Inc., Alan Leventhal, Ph. T., Chairman, 1818 Newkirk Avenue, Brooklyn, New York 11226.

New Jersey State Physical Therapy Society, Inc., Patrick Trotta, Ph. T., President, 4024 Taylor Road, Fairlawn, New Jersey 07410.

Physical Therapy Society of Pennsylvania, Alwen DeWald, Ph. T., President, 1237 Oak Road, Pottsville, Pennsylvania 17901.

Golden State Physical Therapy Association of California, Inc., Merlin L. Kemp, Ph.T., President, 809 Chapala Street, Santa Barbara, California 93101.

Rhode Island Physical Therapy Society, Inc., Mildred Doane, Ph.T., President, 133 Ansdale Road, Cranston, Rhode Island 02910.

Massachusetts Society of Registered Physical Therapists, Walter Holder, Ph.T., President, 480 Washington Street, Norwood, Massachusetts 02062.

We believe that a major segment of the present Medicare system has a built in susceptibility to abuse that is grossly unfair to patients requiring physical therapy services, the government that pays the bill and the physical therapy professionals who provide these essential services.

The only abuses of the Medicare program that have occurred in which physical therapy was an element took place soon after the onset of the Medicare program and was confined to nursing homes. It was a direct result of the unnecessarily cumbersome set-up whereby physical therapists were not able to bill for their own services but were forced to bill through the nursing home. The nursing home then billed the fiscal intermediary who then billed the government. Each step necessitated added cost and left open the door to abuse. Indeed, at the onset of the program it was advantageous for fiscal intermediaries to actively encourage excessive physical therapy treatment as they made a profit from each bill they processed. None of this worked to provide good care for patients and, in fact, tended toward a mass production atmosphere even when there was no formal abuse. Unfortunately, the profession of physiotherapy was identified with this original abuse and still suffers unjustly from this.

There have been some reforms in the system since then, and, indeed, no further evidence of abuse by physical therapists since that early time—a statement difficult to match for most professions. However, the "provider—under arrangement" system still exists, still promotes mediocre care not only in nursing homes but in Home Health Agencies and hospitals as well. Its existence in the present Medicare program still provides the opportunity for abuse by the many parties involved and costs the government 2–3 times per treatment what costs would be if rendered by a private practitioner and billed directly to the fiscal intermediary as other licensed professionals do. A table is included as an addenda to the statement showing some comparative costs.

On the other hand, the private practitioner, working as an independent practitioner under Medicare since PL 92–603 Section 251(a) gave him the opportunity to do so, has had an enviable record. (See letter from Blue Shield in addenda as an example). There have been no cases of fraud or abuse, fees have remained relatively stable and much less than when rendered through "providers". This applies to the fees charged by private practitioners to non Medicare patients as well. The extremely important personal relationships between the referring physician, physical therapist and patient are maintained. This is most often lost in a "provider-under arrangement" set-up where patients are assigned and there are always "more patients where the last ones came from". In a private practice system the referring doctor and patient retain free choice of physical therapist and the quality of care is extremely high as indeed it must be if the private practitioner is to remain in practice.

The oft expressed concern by the Congress and the Bureau of Health Insurance about fragmentation of service and quality control is well meaning but misplaced. Quality is not assured because of additional paperwork and routing patients through agencies but by adhering to high professional standards. It can best be monitored through PSRO and utilization review mechanisms. We are on record as offering our services to BHI in this regard.

We feel that the solution to this problem of higher than necessary costs, mediocre quality and opportunities for abuse is to eliminate the "provider-under arrangement" system. It should be replaced by an expansion of the principle in Section 251 (a) of PL 92–603 but eliminating the totally unrealistic $100 per patient per calendar year limitation and the limitation on locale—now restricted to the physical therapist's office or the patient's home. This would allow the physical therapist to function in the same manner as other professionals. Hospitals and other providers would have the option of either having salaried staff or utilizing private practitioners—but the private practitioners would do their own billing, absorb their own overhead and reimbursement would be the same as for other professionals such as physicians, podiatrists and chiropractors. Studies have shown that hospitals, for example, have far lower costs for physical therapy services with greater flexibility of hours when utilizing private practitioners than with the standard salaried department.

Under the system we recommend, patients would have the option of receiving care in the most convenient setting by a physical therapist of their choice—and the costs would be far lower. This would in no way eliminate the requirement in all states that physical therapy treatment be rendered upon the referral of a duly licensed physician. Physical therapy private practitioners servicing a hospital, for example, would have to meet the same standards and follow the same rules as in a salaried situation. There is no basis for the argument that quality of care would be lessened. On the contrary, quality would be greatly enhanced, costs would be lowered and because of the removal of unnecessary unproductive middlemen the possibilities of abuse are greatly lessened.

We feel the American public deserves a better system of physical therapy care than the one now part of the Medicare program. The program we recommend would be far superior—and yet less costly. We urge the Congress to give it serious consideration. We stand ready to assist in all possible ways.

Sincerely yours,

Alan Leventhal, Ph.T.,
Chairman, Committee on National Legislative Matters.

Enclosures.

SUMMARY OF CHARGES

[Amounts in dollars]

Name of institution	O.P.D. charge	House call
Methodist Hospital of Brooklyn	34	34
L.I. College Hospital	29	68
(Seen by physiatrist)	68	
Brooklyn Jewish Hospital	50	50
Lutheran Medical Center	24	
New York Hospital:		
Therapeutic exercise (gym patient)	35	
Physical therapy modalities (clinic patient)	30.50	
Full manual muscle test	41.50	
Chronaxie	28	
Therapeutic pool	35	
Chest physical therapy	30.50	
Rehab class (example: mastectomy class)	22	
Nerve conduction velocity	28	
Physical therapy additional (gym patient who also receives a modality other than hot pack, paraffin, or whirlpool).	21 (in addition to 35)	
Nassau County Medical Center	25	
North Shore	17.50 + 7.50/modality[1]	
Glen Cove	18	
South Nassau Communities	15 + 7.50/modality[1]	
L.I. Jewish HMC	17.50–20–22	
Long Beach Memorial	17.50	
Peninsular General	35–40	
Hempstead General	10 1st modality + 4 additional modality[1]	
Visiting nurses, town of Oyster Bay		30

[1] Most treatment sessions necessitate 3 or modalities; i.e. heat, massage, exercise, etc.

Summary of Charges

Most privately practicing Physiotherapists charge approximately $15–20 per office visit, inclusive of all modalities. Home visits run from $20–25. In some instances, the first office visit is higher because of the testing, evaluation and initial clerical work involved.

BLUE SHIELD OF WESTERN NEW YORK, INC.,
Buffalo, N.Y., November 17, 1976.

JOINT COMMITTEE OF WESTERN NEW YORK
PHYSICAL THERAPISTS,
Buffalo, N.Y.

Attention: G. M. Foigelman, Ph.T., Chairman,
Professional Relations.

DEAR DR. FOIGELMAN: In response to your letter of November 15, 1976, I am pleased to advise you that Blue Shield of Western New York has not uncovered any evidence of abuse in the processing of claims for physicial therapy. This holds true in both our regular lines of business and Medicare B.

For your edification, I am enclosing a booklet which describes the methods used in our Post Payment review system which you should find quite interesting.

Yours truly,

HENRY F. BECKER,
Vice President, External Operations.

Enclosure.

KENMORE, N.Y., *December 16, 1976.*

REUBEN R. KAISER, DMPT,
Buffalo, N.Y.

DEAR DR. KAISER: I was very sorry to receive your letter informing me that you no longer will be able to accept me as a patient.

The physical therapy you have been giving me as a home bound Multiple Sclerosis patient has helped me very much. I have been able to use the walker quite often in place of the wheelchair since taking treatment from you. I have used other agencies and other physicial therapists in the past but I haven't noticed any improvement as I have with you. Now I find that I will not be covered by Medicare any longer because I have used $100 allotted me, which in reality is only $80, because of the 80% co-insurance clause. In January I will again be eligible for $100 worth of home physical therapy minus the 20% and minus deductible.

I certainly understand and cannot blame you for your policy, but where does that leave me? Isn't there anything that can be done to change the law? Why should I have to take physical therapy from an agency who does not give me first class treatment? Why should I be forced to go to a hospital for out-patient physical therapy when it would be such a hardship for me?

I feel as though my freedom of choice is being taken away from me by not being able to have you as an independent practitioner in physical therapy.

I would like to thank you for all the help you have given me in the past?

Sincerely,

HELENE E. RUDIN.

DECEMBER 20, 1976.

DR. KAISER: This letter is being written on behalf one one of your patients; Mrs. Anna Goodman, to express her family's concern over the seemingly discriminatory stratification of Medicare applicants according to the gravity of their affliction. It is a convoluted logic which allows patients, who do not require the acute care facilities of a hospital any longer, to be penalized for making such progress. Many conditions, as I'm sure you are aware, require extended periods of physical therapy (in particular) to promote the most complete recovery possible. Obviously, the maximum award of eighty dollars per year is not sufficient, since this reimburses the patient for at most four house calls by the therapist. These additional financial and resulting emotional strains certainly do nothing but discourage the patient. Indeed, why not reward those families willing to support and undertake this secondary care for their members? It would certainly encourage more families to participate and consequently raise the quality of care in many overburdened hospitals. One might even speculate as to the probable positive financial ramifications both institutional and individual. I most heartedly encourage you to secure and develop a more ethical and economical health insurance (i.e., Medicare) disbursement plan.

Respectively,

SANFORD BLOOM.

WALKER COUNTY HOSPITAL DISTRICT,
Walker County, Tex., March 1, 1977.

HOUSE COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
House of Representatives,
Longworth House Office Building,
Washington, D.C.

GENTLEMEN: Walker County Hospital District of Walker County, Texas, is a political subdivision of the State of Texas, created by vote of the duly qualified electors of Walker County, Texas, and operating pursuant to the Walker County Hospital District Act (the "Act"), Texas Laws 1971, 62nd Legislature, Regular Session, Chapter 848, Page 2583, et seq., and Article IX, Section 9 of the Constitution of the State of Texas. The District overlays all of Walker County, Texas, and is charged by the Act and the Constitution with "the full responsibility for providing hospital care for its needy inhabitants." In order to perform this constitutional and statutory function, the District is authorized to purchase, construct, acquire, repair or renovate buildings and improvements and to equip and administer the same for hospital purposes. Further, the District is authorized to levy annual taxes, at a rate not to exceed $.75 on the $100 valuation of all taxable property within the District, for the purposes of (i) meeting the requirements of the District's bonds and other indebtedness to the extent that such are payable from taxes, (ii) providing for the District's maintenance and operating expenses, and (iii) making improvements and additions to the District's hospital facilities. The District presently owns a 112 bed acute care general hospital and, in the near future, intends to construct a 140 bed replacement facility. Approximately ten percent (10%) of the total revenues generated by operation of the existing hospital during 1976 took the form of reimbursement from Medicaid for hospital care to Medicaid eligible patients.

As Chairman of the Board of Hospital Managers of the District, I would like to register my concern regarding the potential impact of House Resolution 3 upon the operation of the District and to respectfully request a clarification of Section 11 of the Resolution, which would amend Section 1902(a) of the Social Security Act by inserting the following subparagraph:

(38) provide that no expenditure may be made under the plan with respect to care or services provided to an individual under the plan to the extent that *any agency, organization, or other person* (other than a member of the individual's family) *would have been obligated by a State law or contract to provide such care or services* but for a provision of the State law or contract which limits or excludes such obligation because the individual is eligible for or receives care or services under the plan. (Italic added.)

Should the Resolution be enacted in its present form, the foregoing provision could burden the District with the full obligation of providing hospital care to its needy inhabitants with no reimbursement for the costs of providing care for Medicaid eligible patients. Such a result would occur if it was determined that the District, having a constitutional and statutory obligation to provide hospital care to its needy inhabitants, falls within the definition of "any agency, organization, or other person * * * obligated by a State law * * * to provide such care or services * * *." If the Resolution were so construed, the District would not be entitled to Medicaid reimbursement while the hospitals within the District's neighboring counties, which do not have hospital districts or other public agencies having similarly stated obligations under State law to provide care to the needy, would be entitled to reimbursement for the costs of providing care to Medicaid eligible patients. Similarly, hospitals in an adjoining state whose law does not impose any obligation to provide care to the needy would be eligible for Medicaid reimbursement. In effect, then the Resolution would have the effect of rewarding states or political subdivisions of states for not attending to the hospital needs of the poor. Surely, such a checkerboard application of the Medicaid program is not in the best interests of the people of the State of Texas nor of the nation as a whole. In addition, the Resolution could prevent the District's issuance of revenue bonds in order to finance the construction of a much needed replacement facility since without Medicaid reimbursement the District will be unable to demonstrate a stream of revenue adequate to pay the principal and interest on its bonds and the operation and maintenance expenses of its hospital.

The Act and the State Constitution do not limit the District's responsibility to provide care to the needy such that the District is obligated only to the extent that the Medicaid plan will not provide for such care. Accordingly, it could be argued that since the District's responsibility is not limited, Section 11 of the Resolution will not apply. Such an argument seems specious, however, if the legislative intent is to cause the Medicaid plan to function as payor of last resort where a local political subdivision has assured the responsibility of assisting in the provision of hospital care to the needy.

On behalf of the Walker County Hospital District of Walker County, Texas, I respectfully request that the wording of Section 11 of the Resolution be amended such that political subdivisions like the District will clearly not be included within the definition of "agency, organization or other person . . . obligated . . . to provide such care or services." Such an amendment is essential in order for this District to provide an adequate hospital system to serve its needy inhabitants.

Respectfuly submitted.

BOLEY F. O'BANNON,
Chairman, Board of Hospital Managers.

STATEMENT OF SAMUEL B. WALLACE, WASHINGTON, D.C.

Mr. Chairman and members and chairman of the Subcommittees on Health, this brief exposition is, I believe related directly to the Medicaid and Medicare Hearings now being conducted by the Committees concerning the medicaid and medicare fraud.

What follows is a brief treatise on the antibiotics in which some of the findings of medical research, as recorded by the FDA in the Code of Federal Regulations and the Federal Register are setforth.

At first sight anyone reading this might ask the question "What does a brief treatise on FDA Research and Certification of the Antibiotics have to do with medicaid and medicare fraud?" Two programs which are funded by the Federal Government.

The answer is a great deal. Fraud has been defined as a deception and the taking from another something of value or worth. It may be money, property or health or anything of value. Fraud in medicare and medicaid could refer to the patient recipient who abuses his medicare-medicaid privileges or it could refer to the provider of medicaid-medicare service or treatment—the hospital or the doctor who collects more payments for treatment or services than the doctor or the hospital performs. Or it can refer to an Administrator in the Health Care Field who initiates programs that are ineffective and not workable. Such as the recent controversial "Swine-Flu Program."

In December 1975 when I appeared before the Subcommittee on Health of the House Walys and Means Committee, I indicated in a very small exposition of several pages of the success achieved by the proper application of small quantities of antibiotics to the sick while working from time to time as a medical technician in Brazil. I indicated that I had discovered in the importance and the effectiveness of treating common illnesses through application of antibiotic capsules and nose drops which antibiotic medicines were available by law to the general public in Brazil. I also indicated the amazing times of cure achieved by the proper application of antibiotic medicines. Results that were achieved by primarily applying small quantities of the antibiotic to the immediate area of the illness. For respiratory illnesses, generally, this was found to be by application of the antibiotic to the nose or in some cases orally.

I also indicated that my experience had shown that such cures that resulted by applying the antibiotics in nose-drop form usually occurred in three days time for such illnesses as serious cases of influenza or pneumonia. My experience also indicated that 1½ grams of antibiotic per ounce of decongestant solution when applied three to four times per day would guarantee the same results or even favorable results in shorter periods of time.

I now wish to indicate that based on FDA findings the medicare and medicaid services are not presently geared by the law to take advantage of the scientific findings of research done by the pharmaceutical manufacturers and by the FDA and by competent physicians for the past twenty years. Said findings having been partially recorded in the Code of Federal Regulations and the Federal Register besides the information of FDA Researchers recorded in other places by the FDA.

Because this work by medical researchers and laboratory technicians is partially recorded by the FDA in the Code of Federal Regulations and has been so recorded for the past twenty years, clearly indicating that treatment using the antibiotics should be generally be the first treatment for many common illnesses. I now suggest that the law with respect to medical fraud be made sufficiently explicit so that doctors can be required by law to prescribe such medicines—first—before relying on the less reliable and scientifically less certain medicines, treatments and procedures to produce the desired cure for the illness of the patient.

To some members of the medical profession such a law might seem to be arbitrary and unfair. Yet I pose this question. Should a doctor who receives federal or state funds or even a private fee be permitted to administer second-rate remedies or to prescribe second rate cures that are scientifically and medically less than adequate in the treatment of illnesses? I think not. Particularly when the reputable and recognized pharmaceutical laboratories and the FDA have scientifically determined and attested to the effectiveness of the antibiotics in treating a wide variety of various illnesses and the FDA has reviewed and scientifically verified the findings of research from both sources and have Certified to the "Efficacy and Safety" of the Antibiotic medicines when used for the treating of common illnesses.

The law should make it clear that the doctor who deliberately withholds from the sick patient the proper scientifically proven remedy without good cause and who prescribes less effective medicine or more elaborate and often times unnecessary treatment should be made to answer for his professional abuse, particularly when such acts are knowing and deliberate and are the result of the failure to deliver the services to the patient for which the doctor or the hospital has contracted to deliver by agreement with the government, federal, city or state or even the patient.

It should be obvious that the doctor who deliberately withholds the proper medicine particularly when it has been certified by the FDA as effective has in effect committed an act of fraud and negligence. This fact is today partially recognized in some states such as Massachusettes where doctors are periodically tested to determine whether they still know the most modern medicines and the most modern medical techniques for the most effective treatment of the ills of the patient.

The problem is, however, that there is now no law that make it mandatory that the doctor provide the recommended treatment and as a result, it is still possible for the doctor prescribe deliberately the wrong medicine and sometimes to offer such procedures as unnecessary surgery.

The patient who has been wronged when the doctor suggested the wrong medicine or improper treatment has no recourse except malpractice suits after the fact of the mal-prescribed treatment or actual procedure. Which is like locking the barn after the horse has been stolen.

The same problem is true for other providers of health services including even the government when it knowingly sets-up heatlh programs which do not effectively provide the proper vehicle for health care treatment along the lines scientifically recognized as acceptable, but instead, initiate programs of risky or scientifically dubious value. Such programs when they are at serious odds with medically acceptable and scientifically proven medical practice can also be considered as either fraudulent or negligent; and as such, they represent a misapplication of public funds.

It is ironic but true that a medicaid or medicare patient or any paying or non-paying patient has no guarantee that he will receive the proper medical treatment if he visits a doctor or a hospital. Nor do all states require by law that the doctor is required to use the best method of treatment and remedy possible nor are doctors required by law to use those medicines certified as effective in treating the sick, not even when such medicines have been certified as safe and effective by the FDA of the federal government. And today, in general, a doctor is as free to prescribe an aspirin for a serious cold or pneumonia as he is to prescribe a Certified Antibiotic Medicine. And this despite twenty years of Certification of Antibiotics as *effective and safe* in the treatment of such illnesses.

I therefore shall indicate the FDA findings and I hope to indicate that the FDA itself has in fact laid down the legal basis for requiring that the physician prescribe the antibiotics for most common illnesses.

We will therefore review briefly the FDA tests of Antibiotics and its methods of Certification of those medicines based upon scientific tests which it has recorded and which are also available in various reputable Medical Journals. A list of which is included in this appendix.

I wish to state emphatically that evidence of this scientific testing and the Certification of test results is as I have said before, to be found in the Federal Regulations beginning at least as far back as 1955 under *Title 21 of the Code of Federal Regulations, Chapter 1, Subchapter 430.10 "Code of Federal Regulations October 10, 1962."*

"(a) Prior to the enactment of the 1962 amendments to Federal Food and Drugs and Cosmetics ACT, the only antibiotic drugs required to be submitted to the FDA certification were those medicines containing penicillin streptomycin, chloretetracyclin, chloramphenicol or bacitracin or any derivative of these antibiotics. *Scientific proof of the safety and efficacy (of the antibiotics) was required.*"

In 1972 the FDA published in the Federal Register and for the Code of Federal Regulations Title 21, Food and Drugs, Part 141. Tests and Methods of Assay of Antibiotic and Antibiotic containing Drugs. These tests included tests as to the antibiotics "safety and efficacy." Some of the tests listed included under Subpart A—Biological Test Methods and under 141.5, Safety Test. And under Subpart B. "Microbiological agar tests which tests came to term when the antibiotic was placed in contact with the test organism.

In 141.110 of the Federal Regulations the FDA in the Microbiological Test lists the Antibiotic to be tested, the media sustaining the micro-organism and the name of the test organism or disease and the incubation temperature, etc. For reasons of brevity, I shall list only the principle antibiotics listed by the FDA prior to 1962. Penicillin, streptomycin, chlortetracyclin, chloramphenicol, bacitracin whose efficacy and safety were tested and proved scientifically as were a host of other antibiotics by the FDA at a later date.

The following are only the antibiotics that the FDA Certified to be "Efficacious and Safe" prior to 1962, since the list of antibiotic medicines that FDA now Certifies as "Efficacious and Safe" is now much longer.

Antibiotic	Test Oranism
Penicillin	A Staphylocus Aurous
Chloretracylin	B Bacilus Subtillis
Chloramphenicol	G Bacillus Cereus Var. Mycoidos
Bacutracin	B Sarcina Subflava

(The culture medium being designated as a nutrient such as yeast, or beef extract plus distilled water.)

The Antibiotics in this list as well as many others were tested by the FDA for both their safety and effectiveness against a specified organism and only when the medicine proved scientifically effective and safe for treatment of human beings by the FDA research scientists were such medicines Certified by the FDA as being effective and safe. I have used those antibiotics listed above because they were tested in 1955 and they have been subsquently tested time and time again to verify their strength potency and safety by the FDA. And the FDA has continued to Certify those medicines as both "*safe and effective.*"

The ordinary reader may wonder why I did not go into detail concerning the laboratory tests conducted by the FDA with regard to the efficacy and safety of the antibiotic medicines. The principle reason is that the tests speak for themselves and have been held to be reliable by government researchers, the pharmaceutical laboratories, by reputable medical societies and by competent doctors who have often written for leading medical journals. (A list of which is included as having been designated as reliable by the FDA. This list is enclosed in the appendix as is the verbatim copy of several FDA Tests for "*efficacy and safety*" of the antibiotics as published in the Federal Register and the Code of Federal Regulations.)

Thus there is no question concerning the scientific evidence of the effectiveness of these medicines. And it is also true that the FDA has also tested the antibiotics on *humans and animals* and it has done so before certifying their effectiveness and safety.

The real problem, again, would seem to be why are not these antibiotic medicines widely used in the treatment and cure of most ordinary illnesses on a wide scale?

To that question I can give no satisfactory answer. I can only indicate that there is a certain irrationality in the medical profession when they largely fail to prescribe those medicines which all scientific evidence indicates are effective in treating ordinary common illnesses and which the pharmaceutical laboratories and the federal government Certify that such medicines are effective and safe for the treatment of various illnesses. And I suspect that this fact of the doctors refusal to use the antibiotics widely is one of the principle factors that accounts for the extremely high cost of medical care as well as its general overall ineffectiveness as a profession which can be illustrated by study of Census Bureau statistics for the past twenty years which has not changed substantially for deaths due to common respiratory illnesses and other such illnesses for the past twenty years. And this, despite the discovery, but not the general use of the antibiotics for common illnesses and in particular for respiratory illnesses. This reluctance or superstition on the part of the American Medical Profession as a whole as to the use of the antibiotics for ordinary illnesses. This may explain the wide disparity in medical costs in the United States as compared to other industrial nations and the lack of overall effectiveness in treating ordinary illnesses which may be compared to the better results obtained in those countries where antibiotics are extensively prescribed and used for the treatment of ordinary illnesses.

To say the doctors shown know better is a plain statement of fact. They do know better as evidenced by their writings in medical journals, pharmaceutical manufacturers and the FDA who swear to their "*efficacy.*"

But if this were not enough, there is also the fact that Antibiotics are also used by laboratory methods of which most doctors are familiar for the diagnosis of disease.

And for evidence of this reader is referred to Title 21, Code of the Federal Regulations, Subchapter C, Part 147, entitled: "Antibiotics intended for use in the laboratory diagnosis of disease."

And in these tests the antibiotics were tested as antibiotic discs which discs are tested for their potency or strength and sensitivity for future use as diagnostic tools to test the strength of the medicine and the strength of the medical speciman in the laboratory or in the doctor's own limited laboratory.

The important point here is that this is an acceptable testing method which doctors and laboratory technicians use the effectiveness of the antibiotics against various organisms.

After such tests any doctor who without good reason fails to prescribe an antibiotic is acting in a manner that could be construed in my opinion as criminally negligent.

And if there is any doctor anywhere in the United States who does not know of the work of the FDA particularly as it is related to antibiotics or who has no knowledge of the laboratory diagnostic tools in the form of antibiotic discs by which the laboratory technicians and doctors can, if they choose diagnose various illnesses scientifically with respect-to their treatability by antibiotics and other equivalent medicines then such a doctor would have a difficult time proving that he had ever attended medical school or practiced his internship.

There is also the legal problem of the laws of the United States which prevent purchasing antibiotics in small quantities without a doctor's prescription which is a twofold problem, since doctor's do not often prescribe such medicines even though the federal government has Certified their '*efficacy and safety*" for the treatment of ordinary illnesses.

The conflict of laws in this area is made particularly obvious when one considers the fact that in 1973 the FDA recommended in Title 21 of the Code of Federal Regulations, Subchapter 121.208, Parts 10 to 129 under Subchapter "Antibiotics for Animals" for the prevention of diseases in animals as a preventive medicine:

Quote: "So many grams per ton of food for chickens and turkeys, (elsewhere and in other years the FDA recommends the same antibiotics for preventive medicines are not recommended as preventative medicines for children and in

This particular irony is evident when one considers the fact that such medicines are not recommended as preventive medicines for children and in particular new-born children who have in the United States a relatively high rate of mortality as opposed to other countries with the same or similar standard of living, where antibiotics are given to infants a short time after their birth. And it is interesting to note that expectant mothers are guveb snakk quantities of the milder antibiotics many months before the birth of the child that makes for an easier delivery and a healthier baby and quicker healing process for the new mother.

It would appear from this that the author has gone a long way from medicaid or medicare fraud in this exposition. Not so.

The author has indicated that the FDA Certifies that the antibiotics are safe and efficacious for use in treating a wide range of common and not so common illnesses. That the FDA and the pharmaceutical laboratories test various antibiotics and various batches of such medicines-samples which it Certifies as "Safe and Efficacious", after scientifically proving that fact from tests on animals in the laboratory and in controlled tests on human beings. The antibiotics are also Certified by the FDA and used in medical laboratories and occasionally by physicians as diagnostic tools to determine or to help in the determining of the type of the organism which the doctor has encountered in the medical specimen taken from the patient and which type of medicine according to in Vitro Tests will prove most effective in treating the illnesses which causes the patient to be sick.

I might add that these tests as well as many other numerous laboratory tests are not infallible but they are scientifically best that medical science has to offer in the hands of a competent medical laboratory technician and a competent and honest physician.

And it may reasonably be inferred that any doctor who without good cause turns his back on the proper treatment of his patients for the illness by use or prescription of antibiotics or other proven medicines is in fact turning his back on relatively sound and certain scientific medical evidence. And generally when such a doctor prescribes some other medicine that proves far less effective than the known antibiotics then such a doctor is indeed perpetrating fraud on his patients. And any hospital or agency which collects money for inadequate treatment for an illness for which there is a Certifiable and Scientifically proven adequate medicine or treatment is in fact perpetrating fraud and negligence.

Thus the proposed new H.R. 3 "*to strengthen the capability of the* government to detect, prosecute and punish fraudulent activities under the medicare and medicaid programs, and for other purposes is a good law. And in particular the provisions of section 1877(a) of the Social Security Law as proposed which is to be amended by Section 4 of H.R. 3" shall be guilty . . . (of fraud) with severe penalties.

However, there arises the question of whether the medical profession and medicine as it is practiced in the United States could withstand such a law due to such severe penalties which would in turn pose as severe obstacles to the practice of medicine by most doctors, (as it is now practiced) in the United States.

I do, however, feel that if the law were passed and interpreted and enforced in the manner indicated by the law itself that there would be far fewer unnecessary operations, the number of deaths due to respiratory illnesses would decline by as much as 70 or 80% and the rates of live births would increase substantially provided of course that the doctors were required to prescribe antibiotics when they are necessary, even for patients with ordinary illnesses.

I might add that I also agree with the spokesman for the United Auto Workers, Mr. Glasser who suggested that a ten thousand dollar fine and five years in jail might be a little harsh for someone who borrowed or forged a medicaid or medicare card because he could not get the proper medical care or treatment as a sick person when he needed such care. And I agree also that the remedy for such a problem is a National Health Insurance for all citizens. And a system of Public Health similar to that in Puerto Rico where the antibiotics are readily prescribed by the physician for ordinary illness and those patients who have reason to believe that such medicines certified by the FDA as being effective are effective and can help them in the treatment for their particular common illnesses whether it be a cold, or an eye infection or even a tooth ache or indigestion or other common illnesses such as the mumps or measles. In Puerto Rico the Antibiotics and other needed medicines can be obtained at the pharmacy of the Public Health Center located in various communities on the island. And generally the physicians approval of the patient's request for antibiotics is automatic upon request.

It is also noteworthy that Puerto Rico has a lower mortality rate for its general population than does the United States despite the fact that it has a substantially lower standard of living. Puerto Rico also has a much lower infant mortality rate and a far higher rate of recovery from cancer because the doctors there generally prescribe antibiotics for the treatment of cancer.

In my opinion any medicaid or medicare program or any National Health Insurance Program that does not make room for the dispensing of antibiotics for ordinary illnesses either on a doctors' prescription or the patients request when the need is shown is in fact a fraudulent program in which the best medicines that science has devised may not be made available to the prospective patient and thus to some extent any such program will involve large amounts of wasted money without generally or for the most part providing the necessary remedies to the sick patients of the system.

WASHINGTON, D.C., *February 9, 1977.*

JOSEPH CALIFANO,
Secretary of HEW:

A letter to Secretary via Theodore Chandler, his information officer with HEW.

I, Samuel B. Wallace, affirm that having previously petitioned the former Secretary of HEW David Matthews to make available the known certified by FDA antibiotics for general sale to the public. And upon delivery of petition and also upon previous failure of Secretary of HEW David Matthews to grant an interview on this subject and concerning the Swine Flu Program I instituted a class action suit in U.S. District Court, Washington, D.C.

I affirm that today on February 9, 1977, I requested an interview with the Secretary of HEW in which I requested, in writing, a brief interview of ten minutes with him to discuss the Swine Flu Program and the possibility of an acceptable alternative to the Swine Flu Program based upon 20 years' work (and research), by the FDA as recorded in the Federal Register.

I was referred to the office of Mr. Dixon (or Doctor Dixon?), who is in charge of the Swine Flu Program—he also was not available—and his office referred me to Mr. Theodore Chandler, one of the Information Officers with whom I discussed briefly the Swine Flu Program and some of the issues raised by those who objected to the program and I simply indicated that those objections, with regard to treatability of respiratory illnesses by use of antibiotics in capsule form, were to be found in the Federal Register which indicates that the FDA has certified to efficacy of the antibiotics such as tetracyclin and penicillin in treating respiratory illness such as influenza of all types for many, many years.

I also indicated that as I have previously indicated to both the former Secretaries and to the Disease Control Center, Atlanta, Georgia, that there is an even more effective treatment for respiratory illnesses based upon 1½ grams of antibiotics such as penicillin or tetracyclin in solution of one ounce distilled water or in a known and approved nasal antidecongestant in which the more serious cases of influenza are curable within three days' time. This treatment proved 100 percent effective when I used it personally and treating others who were ill with all types of respiratory that encountered in Brazil.

I also indicated that resumption of a swine flu program in the face of a known acceptable alternative—antibiotics administered in capsule or nose drop form—the swine flu program even in the few borderline cases that the swine flu vaccine or the swine flu vaccine in combination or even the influenza vaccine which when applied to those individuals who do represent a small portion of those inoculated—then the government would be responsible for their negligent death when that death occurred as a result of inoculation by any of flu vaccines when there was an acceptable alternative as indicated by FDA in the Federal Register—namely, the treatment and cure of influenza and respiratory illnesses by means of application of antibiotic capsules or solutions of nose drops.

Affirmed,

SAMUEL B. WALLACE.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., February 14, 1977.

Hon. DAN ROSTENKOWSKI,
Chairman, Health Subcommittee, Ways and Means Committee,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Please find attached a copy of a letter, just received, from my Constituent, Miss Marie Wilmeth, 533 College Drive, Abilene, Texas 79601.

As you will note, Miss Wilmeth is concerned about abuses of the Medicare and Medicaid programs and she has asked that I pass along her views to the appropriate Committees. It is my understanding that your Subcommittee, along with the Subcommittee on Health and the Environment, will be conducting joint hearings on March 3 and 7 to discuss abuses of the two programs. I will deeply appreciate your consideration of Miss Wilmeth's views at the appropriate time.

With my thanks and good wishes, I remain
Sincerely yours.

OMAR BURLESON.

Enclosure.

ABILENE TEX., *February 11, 1977.*

Mr. OMAR BURLESON,
Congressman, 17th Texas District,
% House Post Office, Washington, D.C.

DEAR MR. BURLESON: I do not know the name of the committee, nor its chairman, who is studying abuse and fraud in Medicaid and Medicare, but perhaps you can pass this letter on to that committee.

At least according to the news media the investigation seems to be directed at fraud perpetrated by doctors and other medical personnel. But the fraud committed by the recipients of Medicaid should also be looked into. Apparently there are a number of people, particularly older people, who transfer their assets to others in order to become eligible for Medicaid. There seems to be little investigation of applicants for Medicaid. With so much of the taxpayers' money involved I think a thorough investigation should be made of each applicant, including his assets and income tax return for at least two years prior to his application for Medicaid. If there are laws that prevent such investigation, they should be repealed. Why should an individual's right to privacy enable him to cheat the taxpayer?

Sincerely yours,

MARIE WILMETH.

AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS
Washington, D.C., May 12, 1977.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR CHAIRMAN ROGERS AND ROSTENKOWSKI: This letter responds to your request for views on sections 19 and 20 of the proposed Medicare-Medicard Anti-Fraud and Abuse Amendments contained in H.R. 3. Specifically, sections 19 and 20 relate to the establishment of uniform systems for the "purposes of accounting for and reporting the costs of services" provided by health service institutions. The objective is to secure accurate, comparable data so as to improve analytical and decision-making capabilities relating to health care costs under the Medicare and Medicaid programs and health care policy.

These provisions trace their antecedents to H.R. 4211, a bill introduced by Mr. Moss of California and Chairman Rogers. As you know, the Institute stated its opposition to the original bill primarily because of its unqualified reliance on the use of a mandated accounting and statistical system which required uniform adherence to a functional chart of accounts to accomplish its objectives. In our professional judgment the use of such a system would be extremely costly to implement and unnecessary to the purposes of the legislation. It remains our firm belief that comparative information sufficient to correct deficiencies in the present reimbursement cost reporting under Medicare and Medicaid programs can, on a more expeditious and cost-effective basis, be obtained through a uniform reporting system which relates costs and units of service to function.

With those views in mind, we were pleased to respond to the invitation of the staffs of the Commerce Committee's Subcommittee on Public Health and the Environment and Oversight and Investigations to lend technical assistance to reconstruct the provisions of the original bill. The evolved legislative text which is now before you embodied in sections 19 and 20 of H.R. 3 is, in our opinion, significantly improved.

Our review of these provisions suggests two additional amendments which we believe are essential to clarify the intent of the requirements and to make them truly effective in carrying out the stated objectives. First, on page 98 of Subcommittee working print number 4, line 20, we recommend striking the word "determines" and inserting in lieu the following: "may determine, on the basis of an evaluation of the reports of providers made pursuant to the uniform reporting system,".

Second, on page 99 of the working print, insert "(a)" after the word "and" on line 4 and on line 7, strike "." and insert before the quotation marks the following: "or (b), in the case of the application of the accounting requirement, the provider submits with such application for waiver, a certification that the use of an alternative accounting system by such provider would permit the provider to submit information in the same functional detail and in comparable form as information submitted by a provider which uses the prescribed uniform and accounting and statistical system."

These two amendments are designed to place emphasis and initial reliance on the uniform reporting system to correct deficiencies in the existing program. The uniform accounting and statistical system would be held in reserve and only mandated in circumstances where the Secretary finds that the reports received under the uniform reporting system are not producing adequate information to permit him to measure and compare the operation costs of health service providers. Resort to the much more costly uniform accounting and statistical system would, therefore, be conditional on first testing the results of the uniform reporting system. And, even in these circumstances, providers should be allowed the option to use an alternative system provided they certify its use will allow them to submit information in the same functional detail and in comparable form to information which would result from use of the uniform accounting and statistical system. In other words a provider could avoid the unnecessary expense of installing the uniform accounting system if his present system would produce the same information from point of entry or otherwise.

In our opinion, these amendments together with the changes already incorporated in sections 19 and 20 would make the provisions workable and properly targeted to meet the objectives of this legislation. We are confident that, given experience under the program, the Secretary will find that he need not resort to a broad application of uniform accounting and statistical systems to obtain information adequate to the effective discharge of his responsibilities under the Act and that our original position on this legislation will prove correct and be confirmed in the administration of the program.

Accordingly, on the strength of that confidence and trust in the prudent exercise of HEW's responsibilities under this Act subject to Congressional oversight, the AICPA is prepared to endorse sections 19 and 20 of H.R. 3 if further amended as proposed.

Lastly, let us say that it is comforting to again witness the care and high sense of responsibility which you and other members of the Committee have brought to this task. Accounting concepts are extremely technical and difficult to evaluate. The AICPA is grateful for having the opportunity to give professional guidance to your deliberative processes.

Sincerely,

ROSCOE L. EGGER, Jr.,
Chairman, Federal Government Executive Committee.

[NOTE.—See also earlier communication from AICPA at p. 417.]

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